

ENROLLMENT FORM FOR GROUP INSURANCE

SECTION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT OR TYPE)

Name of Employee		Last	First	Middle	Social Security No.	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's Address			Street	City	State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Name of Employer				Customer Number		Division	Class Dept Code
Employer's Street Address			City	State	Zip Code	Employee Work Location	
Date of Hire (Mo./Day/Yr.)		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Coverage Effective Date (Mo./Day/Yr.)			

Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence	Hours Worked Per Week
<input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____	
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Change in Enrollment <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____	

COVERAGE REQUEST DATA:
 I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage
 Dental

Dependent Spouse Coverage
 Dental

Dependent Child Coverage
 Dental

I wish to **DECLINE** any coverage not checked above for which I may be eligible. For Dental and/or Dependent Dental Coverage, a waiting period may be required before I and/or a dependent can be enrolled. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____

<p>If applying for Dependent coverage (Spouse and Child), complete section below:</p> <p>Number of dependents (including spouse) _____</p> <table border="0" style="width:100%;"> <tr> <td style="width:30%;">Name (Last, First, MI)</td> <td style="width:20%;">Date of Birth</td> <td style="width:10%;">Sex (M/F)</td> </tr> <tr> <td>Spouse: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Child(ren): _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Name (Last, First, MI)	Date of Birth	Sex (M/F)	Spouse: _____	_____	_____	Child(ren): _____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	<p>If dependent children are full-time students in college, vocational or trade school, please complete the following:</p> <table border="0" style="width:100%;"> <tr> <td style="width:50%;">Child(ren)</td> <td style="width:50%;">Name of School</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Child(ren)	Name of School	_____	_____	_____	_____	_____	_____	_____	_____
Name (Last, First, MI)	Date of Birth	Sex (M/F)																											
Spouse: _____	_____	_____																											
Child(ren): _____	_____	_____																											
_____	_____	_____																											
_____	_____	_____																											
_____	_____	_____																											
Child(ren)	Name of School																												
_____	_____																												
_____	_____																												
_____	_____																												
_____	_____																												

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief.

The employee **declares** that he or she is actively at work on the date of this enrollment form.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon, Washington and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Sign Name _____

Print Name _____

Date _____

Employee Signature

Print Name

Date (Mo./Day/Yr)

Terms of eSignature:

Providing your Name, Social Security Number and checking the box below is the same as providing your signature on a hard copy document. By checking the box below you certify that:

- The information provided in the Application is true, accurate and complete.***
- You have read, or have had read to you, the completed Application and understand that any false statement or misrepresentation made in it may result in a loss of coverage.***

I have read and agreed to the terms of eSignature

In order to "SUBMIT" you must read and agree to the terms of eSignature