DentalSelect

Employee Enrollment Form

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8704 **DentalSelect**.com

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

Last Name	First Name	
Street Address		
City	State	Zip Code
Home Phone	Date of Birth (MM/DD/YYYY)	
SSN	Marital Status ☐ Married ☐ Single	Gender ☐ Male ☐ Female
Effective Date (MM/DD/YY)	Date of Hire (Required) (MM/DD/YY)	
Employer's Full Name		
Employer's Address		
Group Number	Subgroup/Dept. #	

Coverage Selection - Confirm available options with your employer. Check all that apply.

Dental

☐ **Discount** - Silver Network
☐ **Co-Pay** - Gold Network
☐ **Co-Pay** - Platinum Network
☐ **PPO** - Gold Network
☐ **PPO** - Platinum Network
☐ **Indemnity** - Platinum Network
Dual Choice : ☐ **High** ☐ **Low**

Insured Vision

☐ **Access Value**
☐ **Access Classic**

Access Choice:
☐ **Vis 4** ☐ **Vis 7**
☐ **Vis 5** ☐ **Vis 8**
☐ **Vis 6** ☐ **Vis 10**

AD&D - Select one

☐ **Employee** – (complete beneficiary info on Designation Form) ☐ **Decline**
☐ **Employee + Family** – (complete individuals covered and sign below)
☐ **AD&D Voluntary** - Amount $ ________________

Beneficiary Designation Required: ____

Individuals Covered - List individuals for whom you are enrolling.

Dental	Vision	AD&D	Name	Gender	SSN	Date of Birth - (MM/DD/YYYY)
☐ Enroll	☐ Enroll	☐ Enroll	Spouse Name - (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll	☐ Enroll	Dependent Name - (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll	☐ Enroll	Dependent Name - (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll	☐ Enroll	Dependent Name - (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll	☐ Enroll	Dependent Name - (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll	☐ Enroll	Dependent Name - (Last, First, MI)	☐ Male ☐ Female		

For additional dependents include the Dependent Enrollment Form

Covered by other DENTAL Insurance?	If Yes, Name of other Dental Insurance Company	Name of Person Insured	Social Security Number
☐ Yes ☐ No			

Confirmation for Dental, Vision & Basic AD&D Insurance Coverage

Authorization ☐ Check here to waive if no coverage is desired ☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, that I will not be entitled to any compensation for my non-participation. I further understand I will not be eligible to enroll in this plan again until next enrollment period.

Signature (Required) ________________________________ Date ________________

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