(DO NOT STAPLE)

Employee Enrollment Form

UnitedHealthcare®

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer

Requested Effective Date of Coverage/Date of Change / /

Group Name

Policy Number

Date of Hire / /

Position/Title

Hours Worked per week

Salary $________ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_______
- ☐ Status Change_______
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Part time to Full time
- ☐ Waiving Coverage
- ☐ Other ______________
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee
- ☐ Termination

Employee Type (Check all that apply)
- ☐ Active ☐ COBRA ☐ State Continuation Start dt ___/___/___ End dt___/___/___
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other ______________

A. Employee Information

If you are waiving all coverage, please complete sections A and F.

Last Name | First Name | MI | Social Security Number ___-__-____

Address | Apt # | City | State | Zip Code | Home/Cell Phone

Date of Birth / / | Gender ☐ M ☐ F | Email Address | Work Phone

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language Preference, if not English

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ________________
Address ________________
ID# __|__|__|__|__|__|__|__|__|__|__| - |__|__|

Primary Care Dentist[3]
Dentist First & Last Name ________________
ID# ________________
Existing Patient? ☐ Yes ☐ No

B. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[4] | Last Name | First Name | MI | Sex ☐ M ☐ F | Date of Birth / /

Spouse | Social Security Number ___-__-____

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ________________
Address ________________
ID# __|__|__|__|__|__|__|__|__|__|__| - |__|__|

Primary Care Dentist[3]
Dentist First & Last Name ________________
ID# ________________
Existing Patient? ☐ Yes ☐ No

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of Kentucky, L.P., UnitedHealthcare of Illinois, Inc. or All Savers Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name ______________________________

B. Family/Dependent Information (continued)

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | | – | | | – | | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# ___|___|___|___|___|___|___|___|___|___|___|___|–|___|___|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | | – | | | – | | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# ___|___|___|___|___|___|___|___|___|___|___|___|–|___|___|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | | – | | | – | | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# ___|___|___|___|___|___|___|___|___|___|___|___|–|___|___|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | | – | | | – | | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# ___|___|___|___|___|___|___|___|___|___|___|___|–|___|___|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D
Employee	☐ ________	☐ ________	☐	☐ $________	☐ $________
Spouse	☐	☐	☐	☐ $________	☐ $________
Dependent	☐	☐	☐	☐ $________	☐ $________

Person	STD	LTD
Employee	☐	☐

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

Employee Name _____

D. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ NO ☐ YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

E. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date ___/___/___

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date	Employee Signature if waiving coverage

G. Signature

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No

vin Rivers CTE Ar

This Spreadsheet was prepared on: 9/24/2015

Effective Date: 01/01/2016

Vision Plan Proposal

Company Name **Plan**	**VSP** **B**
Exam	Every 12 Months
Materials:	
Lenses	Every 12 Months
Frames	Every 24 Months
In Network Copay	
Exam	$10
Single Vision Lenses	Covered in Full
Frames	Up to $130
Contact Lenses:	
Elective	Up to $130
Necessary	Up to $210
Out of Network Allowance	
Exam	Up to $45
Single Vision Lenses	Up to $30
Frames	Up to $70
Contact Lenses:	
Elective	Up to $105
Necessary	Up to $210
Coverage	
Employee Only	$8.91
Employee + One	$15.01
Employee + Dependents	$15.33
Employee + Family	$24.71

This Summary is not an insurance contract, it presents only a brief explanation of the
detailed description of benefits. The rates in this summary are an estimate based on t
rates may vary from those quoted, and will be issued after all enrollment applications
Do not cancel any existing group benefits until final benefits and rates from pro

VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

vsp Vision care for life

Name of Group _____. Department _____ Effective Date _____

1	Social Security No.	Last Name / First Name / MI	Date of Birth

2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP Plan? Y ☐ N ☐	**3**	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

4 Coverage Level and Rates

(√)		Monthly Rates	
		Plan	Plan
☐	Employee Only	$	$
☐	Employee + Spouse	$	$
☐	Employee + Child(en)	$	$
☐	Employee + Family	$	$

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

5	**Last Name / First Name / MI**	**Social Security No.**	**Date of Birth**

Please Return To Your Human Resources Department. Do Not Return To VSP

Signature_____ **Date**_____

dental health OPTIONS®
by Health Resources, Inc.

PRODUCT SUMMARY GUIDE
DENTAL HEALTH OPTION 4

GOOD NEWS! You and your family have the opportunity to enroll in a dental health plan offered by Dental Health Options by Health Resources Inc. Our plans are specifically created to Insure Smiles. We work together with general and specialty dentists who have agreedto provide services at a savings to you. Visit InsuringSmiles.com to Find Your Dentist

Members enjoy:

- No deductibles
- No pre-existing condition clauses
- No claim forms
- A large dentist network, including specialists
- No waiting periods

DENTAL SERVICES COVERED AT 100%*

PREVENTIVE SERVICES
Routine teeth cleaning
Fluoride applications (adult or children)
Sealants (permanent molar teeth only)
Space maintainers (not orthodontic retainers)

DIAGNOSTIC SERVICES
Evaluations (exams)
- Periodic, limited, comprehensive, periodontal

Radiographs (x-rays)
- Surgical films of jaws
- TMJ films
- Cephalometric film
- Complete series
- Panoramic films
- Bitewings

Other procedures
- Pulp vitality tests
- Diagnostic casts

DENTAL SERVICES COVERED AT 80%*

RESTORATIVE
Silver fillings
- Primary teeth/Permanent teeth

White fillings
- Anterior teeth/Posterior teeth

Inlay/Onlay (metallic & porcelain)
Crowns
- Porcelain/ceramic
- Full cast/¾ cast
- Prefabricated stainless steel
- Recementation

Other restorative services
- Protective restoration
- Core buildup including pins
- Pin retention
- Post & core
- Labial veneers (anterior teeth)

ENDODONTICS
Vital pulpotomy (primary teeth only)
Pulp therapy (primary teeth only)
Root canal therapy
- Anteriors/Premolars/Molars
- Retreatment

Apexification
Apicoectomy
Root amputation

PERIODONTICS
Gingivectomy, per quadrant
Crown lengthening
Osseous surgery
Soft tissue grafts
Distal or proximal wedge
Scaling and root planing

IMPLANT SUPPORTED PROSTHETICS (RESTORATIONS)
Crowns, abutment supported
- Porcelain/ceramic/cast metal

ORAL SURGERY
Extractions
- Routine removals or exposed roots
- Surgical removals
- Impactions

Natural tooth reimplantation
Surgical exposure or unerupted tooth
Biopsy, soft tissue
Incision and drainage of abscess
Frenectomy
Excise hyperplastic tissue

ADJUNCTIVE SERVICE
Bleaching (anterior teeth, supervised in office)

DENTAL SERVICES COVERED AT 50%*

PERIODONTICS
Guided tissue regeneration
Full mouth debridement
Periodontal maintenance

PROSTHODONTICS
Removable
- Complete/Immediate dentures
- Partial dentures
  - All acrylic
  - Metal framework, acrylic saddles
- Repairs/Rebase/Reline
- Tissue conditioning
- Overdentures

Fixed bridgework
- Bridge pontics & retainers
- Resin bonded (Maryland) bridge
- Recementation
- Post & core

IMPLANT SUPPORTED PROSTHETICS (RESTORATIONS)
Removable dentures, abutment supported
Fixed bridgework, abutment supported
- Porcelain/ceramic/cast metal

ORAL SURGERY
Alveoloplasty (smoothing of bone)
Removal of benign lesions and cysts
Removal of exostosis
TMJ manipulation under anesthesia
Sialolithotomy

ADJUNCTIVE SERVICES
Palliative emergency treatment
Anesthesia
- General anesthesia
- Intravenous sedation
- Analgesia (nitrous oxide)

Occlusal splints for bruxism
Athletic mouth guards

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in the Employer group contract and your Member handbook, which are available on our website or by calling HRI at 800-727-1444. Employer group acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance. This plan does not meet minimal essential coverage requirements for pediatric dental services as part of the Essential Health Benefits in accordance with the Affordable Care Act (ACA) provisions.

* Applicable to covered services obtained from a network dentist. Non-participating dentists may balance bill.

dental health OPTIONS®
by Health Resources, Inc.

ORTHODONTIC BENEFIT RIDER

Your member ID card indicates whether your plan includes orthodontic coverage and the lifetime maximum benefit level.

TYPE	
A – Ortho Adult & Dep.	B – Ortho Dependent

Procedures listed herein are payable at 50% by Health Resources, Inc. (HRI) up to the lifetime maximum benefit. Benefits are paid on a payment cycle as determined by your Employer's Master Group Contract or Administrative Services Agreement.

Limited Orthodontic Treatment
Comprehensive Orthodontic Treatment
Interceptive OrthodonticTreatment
Treatment to Control Harmful Habits

1. Claims for orthodontic procedures are payable only until the covered dependent reaches the employer group's maximum dependent age & whether or not treatment has been completed or lifetime maximum orthodontics benefits have been paid.
2. Initial orthodontic claims must be submitted by the dentist. Quarterly updates must then be verified by the dentist after treatment is initiated.
3. Benefit payments for orthodontic services are IN ADDITION to the maximum annual benefit payments for non-orthodontic services.
4. Benefit payments stop when plan coverage ends, even if total payments have not reached the lifetime maximum & whether or not treatment has been completed.
5. To receive maximum benefit, patient must be in active orthodontic treatment a minimum of two years while covered by an HRI plan.
6. A lifetime maximum benefit is the maximum amount HRI will pay in orthodontic benefits to a covered person during that individual's lifetime. Once an individual has exhausted his/her lifetime maximum benefit under any HRI plan, additional charges will be excluded.
7. The dentist providing orthodontic services must identify to HRI when orthodontic services began, the estimated total time for treatment, and the total cost for treatment.
8. Benefits may be paid even if orthodontic services began before dental coverage. The total cost for treatment will be divided between two periods:
   a. Period #1: the date treatment started to the date dental coverage began (this cost will NOT be covered);
   b. Period #2: the date dental coverage began to the date when treatment should be completed (this cost will be covered for the time REMAINING in the treatment program).

Payments are subject to the limitations previously described.

This plan does not meet minimal essential coverage requirements for pediatric dental services as part of the Essential Health Benefits in accordance with the Affordable Care Act (ACA) provisions

Twin Rivers CTE Area

This Spreadsheet was prepared on: 9/24/2015

Effective Date: 01/01/2016

Dental Plan Proposal

Company Name	**HRI DH 04**
Deductible	
Individual	N/A
Family	N/A
Coinsurance	
Preventive & Diagnostic	100%
Basic	80%
Major	50%
Annual Max	$1,000
Orthodontia	N/A
Lifetime Max	N/A
Waiting Period for Major	N/A
Coverage	
Employee Only	$37.20
Employee + One	$75.30
Employee + Dependents	$83.00
Employee + Family	$123.80

This Summary is not an insurance contract, it presents only a brief explanation of the b
detailed description of benefits. The rates in this summary are an estimate based on th
rates may vary from those quoted, and will be issued after all enrollment applications l

dental health OPTIONS®
by Health Resources, Inc.

www.hri-dho.com
PO Box 659 Evansville IN 47704-0659
Tel: (800) 727-1444 Fax: (812) 424-2096

ENROLLMENT APPLICATION – SUBSCRIBER

ALL INFORMATION IS REQUIRED IN ORDER TO COMPLETE ENROLLMENT, MAKE CHANGES AND PROCESS CLAIMS

Group Legal Name :	Group Number:	Site Location:	DHO Plan:

Coverage Election:
- ☐ Employee ONLY
- ☐ Employee and Spouse/Partner
- ☐ Employee and One Dependent
- ☐ Employee and Dependents
- ☐ Employee Spouse/Partner & Dependent(s)

☐ **Decline**: I decline coverage for myself & dependent(s)

☐ **OPEN ENROLLMENT:**
- ☐ Subscriber Declining Coverage for Upcoming Plan Year
- ☐ Subscriber Terminating Dependent Coverage for Upcoming Plan Year
- ☐ Coverage Gained
- ☐ Death
- ☐ Divorced or Legal Separation
- ☐ Married
- ☐ No Longer Full Time Student
- ☐ Over Age Limit

☐ **STATUS CHANGE:**
- ☐ Employment Term Involuntary
- ☐ Employment Term Voluntary
- ☐ Reduction Hours of Employment
- ☐ Coverage Gained
- ☐ Coverage Lost
- ☐ Death
- ☐ Divorced or Legal Separation
- ☐ Married
- ☐ No Longer Full Time Student
- ☐ Over Age Limit
- ☐ Plan Change

DATE (format): MM/DD/YYYY
Effective Date:
Date of Status Change:
Date of Employment Term:
Month Covered Through:
Coverage for Members is offered on a monthly basis to match premium billing.

COBRA:
Group Administration (If applicable)
☐ Term of COBRA coverage by Group
☐ Reinstatement of Subscriber
Billing: ☐ Separate Group ☐ Site Location

Action Requested					
☐ Add ☐ Term ☐ Update Info	**EMPLOYEE (Subscriber)** Social Security Number:			Employee Hire Date: **MM/DD/YYYY** ☐ Hourly ☐ Salary	
	Last Name	First Name	MI	Birth Date	Relationship to Subscriber SELF
	Employee Home Address	City		State	Zip
	Email	Contact Phone Number		☐ Single ☐ Married ☐ Divorced or Legal Sep.	
	Employee Work Address	City		State	Zip

Action Requested					
☐ Add ☐ Term ☐ Update Info	**SPOUSE/PARTNER** Last Name	First Name	MI	Birth Date	Relationship to Subscriber SPOUSE/PARTNER
	Social Security Number	Other Dental Coverage			
	Spouse/Partner Home Address if Different than Subscriber	City		State	Zip

Action Requested					
☐ Add ☐ Term ☐ Update Info	**DEPENDENT** Last Name	First Name	MI	Birth Date	Relationship to Subscriber DEPENDENT
	Social Security Number	Other Dental Coverage and Guardian Birth Date			☐ Physical Disability ☐ Full Time Student ☐ Court Order
	Dependent Home Address if Different than Subscriber	City		State	Zip

Action Requested					
☐ Add ☐ Term ☐ Update Info	**DEPENDENT** Last Name	First Name	MI	Birth Date	Relationship to Subscriber DEPENDENT
	Social Security Number	Other Dental Coverage and Guardian Birth Date			☐ Physical Disability ☐ Full Time Student ☐ Court Order
	Dependent Home Address if Different than Subscriber	City		State	Zip

REQUIRED DOCUMENTATION: if you have checked any of the above boxes that apply:

Physical Disability: Requires statement from physician for coverage dependents only.	**Full Time Student:** School schedule may be required. Contact employer's benefits administrator for submission procedure.	**Court Order:** Requires court order that states dependent responsibility	**Guardianship Papers:** Required for dependents other than adopted, biological or step-children.

SIGNATURE, RELEASE AND ASSIGNMENT:

By submitting this application, subscriber understands that coverage may not change until next open enrollment period, including coverage on dependents unless there is a change in family status. If coverage is approved and issued, subscriber authorizes Health Resources, Inc. (HRI), to make payment of any benefits directly to the dentist as the supplier of services rendered. Subscriber understands that the dentist(s) chosen to use are independent contractors, and are not employees of HRI and authorizes the dentist to release to HRI any information regarding history, symptoms, treatment, examination results or diagnosis. Subscriber further authorizes HRI and the dentists providing services to transmit by any means any and all information regarding services performed for self and dependents enrolled under this plan as may be required for the payment or evaluation of claims. A photo copy of this authorization shall be considered as effective and valid as the original. Subscriber understands they have the right to receive a copy of this authorization.
If this application is accepted, the information herein is an integral part of the plan. 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 will be reported.

Signature of Employee_____ Date_____

Signature of Employer Benefits Administrator/Authorized Agent_____ Date_____
BENEFIT ADMIN SIGNATURE NOT REQUIRED IF SUBSCRIBER APPLICATION IS SUBMITTED WITH EMPLOYER APPLICATION or Renewal.

HRI_____