



101 Parklane Boulevard – Suite 301, Sugar Land, TX 77478
 Customer Service 877.493.6282 Fax 281.313.7155
Product Insurance Enrollment Form

Employer Name: _____	Group Number: _____
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Please Complete All Information Below

<u>Social Security or Alternate ID#</u> _____	<u>Effective Date</u> <u>Month / Day / Year</u> / /	<u>Start Date</u> <u>Month / Day / Year</u> / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
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<u>Full Name Last First Middle Initial</u> _____	<u>Date of Birth</u> <u>Month / Day / Year</u> / /	Home Phone _____ Work Phone _____
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Home Address: _____ _____	<u>Dental</u> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+ Spouse <input type="checkbox"/> Employee+ Child(ren) <input type="checkbox"/> Employee+ Family <input type="checkbox"/> Dental Waived
Do you have any other Dental coverage? If so, please provide Carrier: _____	

DHMO ONLY: Please List Provider Info -Name, Address & Phone: _____

<u>Dependent Coverage</u>		<u>DOB</u> Month / Day / Year	<u>Dependent Current Coverage?</u> -Choose Below	
<u>Spouse Name</u> (Last), (First), (Middle Initial)		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Current Carrier:
DEPENDENT	1	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

Fraud Warning (Not Applicable in AZ, FL, MD or VA): 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 (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

Fraud Warning (FL only): 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.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Date _____ Employee Signature: _____

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date _____ Employee Signature: _____