

**DentAssure Dental/Vision Plans
Employee Enrollment Form**

For Company Use Only

ER #

Loc. #

Eff. Date

PLEASE PRINT IN SPACE PROVIDED

Active

COBRA

Cal COBRA

EMPLOYER INFORMATION

EMPLOYER NAME	LOCATION	GROUP NO.
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EMPLOYEE APPLICANT

LAST NAME		FIRST NAME		M.I.
STREET ADDRESS		CITY	STATE	ZIP
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ()		BIRTH DATE / /
SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	FULL TIME EMPLOYMENT DATE / /	MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/>	OCCUPATION / TITLE	EMPLOYMENT STATUS ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/>

COVERAGE - Check Those That Apply

EMPLOYEE SPOUSE CHILDREN MY FAMILY REQUESTED EFFECTIVE DATE: _____

DEPENDENT INFORMATION

	Last Name	First Name	MI	Date of Birth	Age	Sex	Social Security Number
Spouse				/ /			
Child				/ /			
Child				/ /			
Child				/ /			
Child				/ /			

Are any of your children students over the age of 19? Yes No. If yes, please list their names below.

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL COVERAGE? _____
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

REFUSAL/WAIVER - Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE COVERAGE FOR: MYSELF MY SPOUSE MY CHILDREN MY FAMILY
REASON FOR REFUSAL: _____

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Employers Voluntary Benefit Insurance Trust under the Policy GH-1112-38220 (Indemnity) or GH-1112-38222 (PPO Schedule) or GH-1112-38223 (PPO UCR) or GH-1157-38221 (Vision) group dental or vision plan offered by my employer and authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I declare all answers true and complete.

DATE	SIGNATURE X
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Underwritten by:
Security Life Insurance Company of America
Minnetonka, MN 55343

Administered by:
Integrity Administrators, Inc.
P.O. Box 13128, Sacramento, CA 95813-3128
Phone: (800) 562-9383 · Fax (916) 921-3383