

enrollment/change/waiver group insurance form

COBRA: If individual is a continuee:	Qualifying event _____
	Date of event _____



The Standard[®]

Positively different.

P.O. Box 82622 / Lincoln, NE 68501-2622
800-497-7044 / Fax: 402-467-7338

Policy and Div. # 160-_____ Cert. # _____

Name and Address of Employer (Policyholder) _____

to enroll **Dental** To terminate all coverages
employee information Marital Status Single Married

Select plan High Middle Low

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____ Male Female

Full time date of hire _____ Rehire: Rehire date _____

Occupation _____

Hours worked each week _____ Are your earnings paid: Hourly or Salaried

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another dental insurance plan? **Employee:** Yes No **Dependents:** Yes No

dependent coverage information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

print full legal name (last, first, MI)	add	drop	relationship	sex	date of birth	social security number
1 _____						
2 _____						
3 _____						
4 _____						
5 _____						
6 _____						

please sign (employee/policyholder) **This enrollment form provides dental benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. **THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:** I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

Employee Signature (do not print) _____ **Date** _____ **Policyholder Signature (do not print)** _____ **Date** _____

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____	Effective Date _____	Class _____	Dep. Code _____
Dependent late entrant date _____			

2 to change

Name change New Name _____ Old Name _____

Add dependent coverage

If due to marriage, what is the date of marriage? _____

If due to birth/adoption, what is the date of event? _____

If due to loss of coverage, date and reason: _____

If other, the date of event and please explain: _____

Drop dependent coverage Number of dependents still covered: _____ Effective date of drop: _____

Due to divorce Due to death Due to annual election period

Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

myself (does not apply to TRUST policies) **spouse only** **child(ren) only** **spouse and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.