DENTAL PLAN ENROLLMENT FORM

SECTION I – GENERAL INFORMATION (To be completed with the assistance of the Human Resource Department of the Employer)

Employer Name: Clarke College | Group #: 164 | Division: | Plan:

Reason for completing this form (check one and provide requested information):

o New Hire or o Re-hire/Recall | Hire date: / / | Effective date: / / | *(Attach certificate of prior coverage, if any.)*

o Part-time to Full-time status change | Date of change: / / | Effective date: / / | *(Attach certificate of prior coverage, if any.)*

o Marriage/Birth/Adoption | Date of event: / / | Effective date: / / | *(Attach certificate of prior coverage, if any.)*

o Special enrollment (Employee or dependent lost other coverage.) | Date coverage lost: / / | *(Attach certificate of prior coverage, if any.)*

o Late enrollment (Existing employee or dependent has been without coverage for more than 63 days.)

o Terminate coverage for one/all dependents | Effective date: / / | List dependents who are no longer covered:

Benefits elected other than Medical or Dental:

SECTION II - EMPLOYEE INFORMATION *Note: This application does not guarantee coverage.*

Employee Name Last: ___ First: ___ MI:

Social Security #: ___-___-___ Birth date: ___/___/___ Sex:

Marital Status: o Married o Single o Divorced o Legally Separated o Widow/Widower

Address: ___ Phone: (___)

Street/ P.O. Box *City* *State* *ZIP*

E-Mail Address: ___

Dental Coverage Applied For:

- o Single (complete ONLY Sections II and VI)
- o Employee plus Spouse (Sections II - VI)
- o Employee plus One Child (Sections II - VI)
- o Family (complete Sections II – VI)
- o No dental coverage with SISCO (Section II)

DECLINATION SIGNATURE

I hereby certify that I have been offered an opportunity to become covered under the Plan sponsored by my employer and I have decided NOT to take advantage of this offer. I understand that in the event I desire the coverage offered but at a later date, my application will be subject to the provisions and limitations of the Summary Plan Document.

o I do o Do not have other coverage

___

SIGN HERE ONLY IF YOU DO NOT ELECT ANY SISCO COVERAGE

SECTION III - DEPENDENT INFORMATION *Note: This application does not guarantee coverage.*

Relationship:	Name *(first, middle, last)*:	Sex:	Birth date:
o Spouse o Common Law Spouse o Other			
o Natural or Adopted o Step Child o Foster Child o Other			
o Natural or Adopted o Step Child o Foster Child o Other			
o Natural or Adopted o Step Child o Foster Child o Other			
o Natural or Adopted o Step Child o Foster Child o Other			
o Natural or Adopted o Step Child o Foster Child o Other			

If dependent is 19 years or older and a full-time student, please provide the following:

Full-time Student Name:	Social Security #:	Name and Address of School:	School Phone Number:

SECTION IV - OTHER COVERAGE

PART A: Spouse **Date of Marriage** ____/____/

Name and City of Employer: ___

Does your spouse have other coverage:

o No other coverage o Single coverage o Employee and Spouse

o Employee and Children o Family coverage

If family coverage is in place through your spouse's employer, please list the children covered under this plan and what type of coverage exists:

o Medical o Dental o Prescription Drug o Vision

Children's Names: ___

PART B: Ex-Spouse *(if applicable)* **Date of Divorce:** ____/____/

Name:

Address:

Social Security # *(if available)* : ___-___-

Name and City of Employer:

If family coverage is in place through your ex-spouse's employer, please list the children covered under this plan and what type of coverage exists:

o Medical o Dental o Prescription Drug o Vision

Children's Names: ___

SECTION V - LEGAL PROVISIONS

1) Do all the children listed above depend on you for financial support? o Yes o No **If No, list who does not:**___

2) Will you claim all of the above children on this year's income tax return? o Yes o No **If No, list who will not be claimed:**___

3) Do all the children listed above reside with you more than 6 months a year? o Yes o No

If you answered "No" to #3, provide the following custody information:

Dependent Name:	Custody Arrangement:
	o Joint custody - less than 6 months per year o Visitation rights o No contact
	o Joint custody - less than 6 months per year o Visitation rights o No contact
	o Joint custody - less than 6 months per year o Visitation rights o No contact

4) Does a divorce decree or court order make provisions as to who is responsible for health insurance/tax exemptions for any of the dependent children?

o Yes o No ***If Yes, please provide a COPY of the section of the divorce decree or court order relating to tax exemptions and insurance.***

SECTION VI - SIGNATURE

To the best of my knowledge, the above information is complete and true, and I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage and/or refuse payment of claims. Updates or additions to this information may be required periodically. I hereby request the amount(s) and Forms of Coverage for which I am or may become eligible and hereby authorize my employer to deduct any required contributions from my earnings (pre-tax, if applicable). By signing, I authorize all physicians, Ph.Ds, hospitals, druggists and all agencies including other claim administrators, to furnish to Self Insured Services Company (SISCO), HEALTHCORP, and the health plan, full information pertaining to the diagnosis and treatment of medical, mental health, and drug and alcohol conditions. I understand that the purpose or need for this disclosure is to verify eligibility of benefits. I also understand that this consent is subject to revocation at any time through a written submission to SISCO.

___ ___

Sign your name | Date completed | Spouse signature | Date completed