TripleChoicePlan

EXCLUSIVE DENTAL AND VISION PROGRAMS

Office Use Only	Plan:	Account Number:
	Member Number:	Code:

- If you wish to refuse coverage for yourself or a dependent, please complete the waiver at the bottom of the page -

Employer Section

Please check one box only ❏ Initial Enrollment ❏ Change ❏ Open Enrollment	Effective Date: ______/______/__________ mm dd yyyy	Name of Company: (division no.) Account Number:

Employee Section: Please print all information. Sign and date this form below.

Employee Name:

Home Address: (street) (city) (state) (zip)

Home Phone:	Work Phone	Fax:

Marital Status: ❏ Single ❏ Married ❏ Divorced ❏ Domestic Partner ❏ Eligible Children:___________

Date of Hire: ______/______/__________	Occupation:	Total hours worked per week: ❏ Less than 30 ❏ More than 30

Benefit Coverage Options:

Group PPO Dental ❏ PPO 1 ❏ PPO 2 ❏ PPO 3 ❏ EPO A ❏ EPO B ❏ EPO C	Vision Selection ❏ Vision ❏ Buy Up (B) * Vision Office Number__________
Dental Health Services DHMO (prepaid) Plan ❏ Gold Plan ❏ Silver Plan ❏ Bronze Plan * Dental Office Number (DHMO Only)_________	* If dental or vision office is not selected or is no longer available, you will be assigned an office by the plan

Enrollment Information: Please provide all information for yourself and each dependent to be enrolled.

	Last Name	First Name	Sex	Birth Date mm/dd/yyyy	Full-time Student*	Social Security	Dentist # (2/family)	Vision # (1/family)	Change Status of Dependents
Self			M F		n/a				❏ Add ❏ Remove
Spouse			M F		n/a	n/a		n/a	❏ Add ❏ Remove
Child			M F		Y N	n/a		n/a	❏ Add ❏ Remove
Child			M F		Y N	n/a		n/a	❏ Add ❏ Remove
Child			M F		Y N	n/a		n/a	❏ Add ❏ Remove

* For all dependents age 19 or older, please provide proof that he/she is a full-time student.

I hereby declare that I am a full-time employee of the employer indicated above and that I regularly work for my employer at least 30 hours per week. Additionally, I hereby request the group benefit plans for which I am or may become eligible under the policies or contracts issued by the Insurer or Benefit Provider. I authorize the deductions from my earnings of any contributions I may have to make toward the cost and understand that my request for group benefits shall include this form or any other form which may be required. All information given by me on this form is true and complete and is offered as a request to grand benefit coverages.

Employee Signature: X ____ **Date:** ____________________

Dental HMO benefits provided by Dental Health Services. DHMO Vision provided by Vision Plan of America

Waiver of Coverage: Complete this section only if you are refusing dental coverage for yourself or a dependent. Then sign, date and return this form to your employer

Refusing coverage for: ❏ Self ❏ Spouse ❏ Child(ren)

Reason for Refusal: ❏ Covered under spouse's Group Insurance Plan. Name of Plan: ______________________________

❏ Other/Explain: ____

I understand that if I later wish to enroll or re-enroll, I must provide satisfactory evidence of insurability to the Insurance Company or be subject to limited benefits for a specified period of time. I also understand that I may not be eligible for all plans made available through my employer.

Employee Name (print): ____________________________ **Company Name:**____________________________

Employee Signature: X ____________________________ **Date:**____________________________