DentalSelect

Employee Enrollment/Change Form

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8704 **DentalSelect**.com

Must be completed in FULL – PLEASE PRINT – Enrollment/Change Form is not valid without signature(s) on page 2 of this form and may be returned if not complete.

☐ Add ☐ Terminate ☐ Change	**Employee Last Name**	**First Name**			**MI**
Mailing Address		**City**		**State**	**Zip Code**
SSN/Member #		**Home Phone #**	**Date of Birth** (MM/DD/YYYY)	**Marital Status** ☐ Married ☐ Single	**Gender** ☐ Male ☐ Female
Employer's Full Name		**Effective Date** (MM/DD/YY)		**Date of Hire (Required)** (MM/DD/YY)	
Employer's Address		**Group Number**		**Subgroup/Dept. #**	

Coverage Selection - Confirm available options with your employer. Check all that apply.

Dental Plan - Utah & Texas Only

☐ Discount - Silver
☐ Co-Pay - Gold ☐ High ☐ Low
☐ Co-Pay - Platinum ☐ High ☐ Low
☐ Other ___________________
☐ Co-Insurance PPO* - Gold ☐ High ☐ Low
☐ Co-Insurance PPO* - Platinum ☐ High ☐ Low
☐ Co-Insurance Indemnity - Platinum ☐ High ☐ Low

Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.

AD&D Plan Option - Utah & Texas Only

Contributory - Amount $_______________
☐ Employee (Complete beneficiary info on Designation Form)
☐ Employee & Family (Complete individuals covered and sign page 2)

Voluntary
☐ AD&D - Amount $_______________
(Complete beneficiary info on Designation Form)
Principal Sums range from $10,000 to $250,000. Refer to plan flyer for specifications.

Dental Plan - All Other States

☐ Co-Insurance PPO/MAC - Platinum ☐ High ☐ Low
☐ Co-Insurance Passive PPO - Platinum ☐ High ☐ Low
☐ Other ___________________
Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.

Vision Plan - All States

☐ Vis 6z ☐ Vis 7z ☐ Vis 8z ☐ Other _____________

Reason/Status - (Required for all requested changes - Notice must be given to Dental Select within 30 days)

☐ **New Group** - Initial Enrollment
Effective Date:____/____/_____

☐ **Open Enrollment**
Effective Date:____/____/_____

☐ **New Hire** - Apply Probationary Period (if Applicable) to determine effective date
Hire Date:____/____/_____
Effective Date:____/____/_____

☐ **Rehire**
Date of Layoff:____/____/_____
Rehire Date:____/____/_____

☐ **Loss/Gain of Coverage** - Employee and/or Dependent
Date of Change:____/____/_____
Effective Date:____/____/_____

☐ **Employee Part to Full Time**
Date of Change:____/____/_____
Effective Date:____/____/_____

☐ **Other** - Mark One
☐ Marriage ☐ Termination ☐ Death
☐ Divorce ☐ Birth ☐ Address Change
☐ Leave of Absence ☐ Adoption ☐ Name Change
Date of Change:____/____/_____
Effective Date:____/____/_____

☐ **COBRA** - Mark One
☐ 18 months - Termination ☐ 36 months - Divorce. Loss of Subscriber, Etc.
Effective Date:____/____/_____
Cancel Date:____/____/_____

Individuals Covered - List individuals for whom you are enrolling, changing and/or terminating.

☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Spouse Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth -** (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth -** (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth -** (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth -** (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth -** (MM/DD/YYYY)

* Where permitted by law

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Employee Last Name	First Name	SSN/Member #	Group Number

Authorization of Coverage/Change

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claims and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Fraud Warning for Kentucky Applicants:
WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, I will not be entitled to any compensation for my non-participation.

Employee's Signature (Required) **Date Signed (MM/DD/YYY)**

ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE Property and Casualty Insurance Company.
ace usa

Coordination of Benefits

Covered by other DENTAL Insurance?
☐ Yes ☐ No

If Yes, Name of other Dental Insurance Company

Name of Person Insured

Social Security Number

Waive Coverage

Check here to waive if no coverage is desired
☐ Dental ☐ Vision ☐ AD&D

Check here to waive if no coverage is desired because you have additional coverage through another policy
☐ Dental ☐ Vision ☐ AD&D

Authorization for Change - (Required for all requested changes - Notice must be given to Dental Select within 30 days)

Employer Name:	Employer Title:

Employer Signature **Date Signed (MM/DD/YYYY)**