

**STANDALONE DENTAL
GROUP INSURANCE
EMPLOYEE ENROLLMENT FORM**



PRINT ALL INFORMATION – USE INK, NOT PENCIL TO BE COMPLETED BY THE EMPLOYEE

Group # _____ Certificate # _____ Name of Employer _____

Employer Phone # _____ Employer Fax # _____

Check One: 1st Enrollment Adding Dependent(s) (Date of Marriage/Birth) _____

A. EMPLOYMENT AND PERSONAL INFORMATION

Name of Employee Last		First	MI	<input type="checkbox"/> Male	<input type="checkbox"/> Single
				<input type="checkbox"/> Female	<input type="checkbox"/> Married
Home Address Street	City	State	Zip	Home Phone () -	
Full-time Employment Date: / /		Position:		Hours worked per week:	
Employee Status: <input type="checkbox"/> Active <input type="checkbox"/> Continuation <input type="checkbox"/> COBRA			Effective Date of COBRA/Continuation: / /		

B. COVERAGE REQUESTED

DENTAL: None* Employee Employee & Spouse Employee & Children Full Family

*If waiving Dental, provide the reason for waiving: _____

C. PERSONS TO BE COVERED

Name (Include yourself and all family members to be insured) Last Name	Relationship	Date of Birth (Mo/Day/Yr)	Social Security Number	Full-time Student (age 19+)
First Name	Employee	/ /	- -	
	Spouse	/ /	- -	
	Child <input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child <input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child <input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No

D. IMPORTANT NOTICE

I hereby represent that I am an employee of the participating employer and that the statements and answers on this enrollment form are true and complete to the best of my knowledge and belief and will be used by Fortis Insurance Company to determine eligibility for insurance for myself and persons listed on this enrollment form as my spouse or dependent children.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of insurance. I understand that (1) the answers given will be the basis of any coverage provided; (2) coverage, if approved, may be subject to limitations regarding pre-existing conditions as defined by the certificate of insurance; (3) if I, my spouse or dependent children waive coverage and decide to apply for coverage at a later date, benefits may be deferred for a specified period of time; and (4) coverage will not be effective until I receive notice that this enrollment form has been approved by the Company.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, dentist, hospital, clinic, veterans administration facility, insurance company or consumer reporting agency to give to Fortis Insurance Company any information regarding diagnosis, treatment and prognosis with respect to any dental condition or any other information pertaining to employment or other dental insurance for me or any member of my family shown on this enrollment form. I further authorize Fortis Insurance Company to disclose such information to any third parties utilized to provide services or benefits relating to my insurance contract; or any request for such information which Fortis is legally required to provide. I agree that this authorization shall remain valid for two years from the date signed and that a photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee's Signature _____ Date _____