☐ *DHMO Only Plan*

101 Parklane Boulevard – Suite 301, Sugar Land, TX 77478
Customer Service 877.493.6282 Fax 281.313.7155

Product Insurance Enrollment Form

Employer Name:	Group Number:

Please Complete All Information Below

Social Security or Alternate ID#	*Effective Date* Month / Day / Year / /	*Start Date* Month / Day / Year / /	☐ *Male* ☐ *Female*

Full Name Last First Middle Initial	Date of Birth Month / Day / Year / /	*Home Phone* _____ *Work Phone* _____

Home Address: _____

_____

Do you have any other Dental coverage? If so, please provide Carrier: _____

Dental	*Vision*
☐ Employee Only	☐ Employee Only
☐ Employee+ Spouse	☐ Employee + Spouse
☐ Employee+ Child(ren)	☐ Employee + Child(ren)
☐ Employee+ Family	☐ Employee+ Family
☐ Dental Waived	☐ Vision Waived

DHMO ONLY: Please List Provider Info -Name, Address & Phone: _____

_____

Dependent Coverage — **Spouse Name** (Last), (First), (Middle Initial)		*DOB* Month / Day / Year	*Dependent Current Coverage? -Choose Below*	
		/ /	☐ Yes ☐ No	Name of Current Carrier:
CHILDREN	*1* *M or F*	/ /	☐ Yes ☐ No	
	2 *M or F*	/ /	☐ Yes ☐ No	
	3 *M or F*	/ /	☐ Yes ☐ No	
	4 *M or F*	/ /	☐ Yes ☐ No	
	5 *M or F*	/ /	☐ Yes ☐ No	

Fraud Warning (Not Applicable in AZ, FL, MD or VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact pmaterial thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal an civil penalties.

Fraud Warning (FL only): Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Date _____ **Employee Signature:** _____

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date _____ **Employee Signature:**_____