dental health OPTIONS by Health Resources, Inc.

InsuringSmiles.com
PO Box 659 Evansville IN 47704-0659
800 727-1444 Fax: (812) 424-2096

ENROLLMENT APPLICATION – SUBSCRIBER

ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES, AND PROCESS CLAIMS

Group Legal Name:	Group Number:	Site Location / Cabinet:	DHO Plan:
University of Southern Indiana	00084234		#6

☐ NEW GROUP ENROLLMENT	☐ OPEN ENROLLMENT	☐ EVENT CHANGE	☐ COBRA (if applicable)
DATE(MM/DD/YY): Coverage Start Date:_______________ Coverage End Date:_______________ ☐ **Decline**: I decline coverage for myself & dependent(s)	**COVERAGE ELECTION:** ☐ Employee Only ☐ Employee and Spouse/Partner ☐ Employee and One Dependent ☐ Employee and Dependents ☐ Employee and Family (Spouse/Partner &Dependent(s)	**EVENT:** ☐ New Hire ☐ Termination ☐ Coverage Gained ☐ Coverage Lost ☐ Death ☐ Marriage	 ☐ Reduction of Hours Worked ☐ Divorced or Legal Separation ☐ Over Age Limit ☐ No Longer Full Time Student ☐ Birth / Adoption

EMPLOYEE (Subscriber) ☐ Add ☐ Term ☐ Update	Social Security Number		Employee Hire Date		
	Last Name	First Name	MI	Birth Date	
	Home Address	City		State	Zip
	Contact Phone Number	Email ☐ Receive electronic EOB statements			
SPOUSE / PARTNER ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date		Other Dental Coverage? ☐ Yes ☐ No	
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	
DEPENDENT ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date	☐ Disability / Exception ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No	
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	
DEPENDENT ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date	☐ Disability / Exception ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No	
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	
DEPENDENT ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date	☐ Disability / Exception ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No	
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: 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.

Employee____ Date____________________

Employer Benefits Administrator/Authorized Agent________________________ Date____________________

Benefits Administrator signature not required if Subscriber application is submitted with Employer application or renewal. HRI____________________