ASSURANT Health

DENTAL ONLY GROUP INSURANCE EMPLOYEE ENROLLMENT FORM

Instructions for completing this enrollment form

1) Each eligible employee enrolling for dental coverage must complete the entire enrollment form except **Section B**, which must be completed only if enrolling in an existing plan or making changes to an existing plan.
2) Any eligible employee waiving dental coverage needs only to complete and sign the Waiver of Coverage in **Section E**.
3) This enrollment form must be completed in ink.
4) If your employer offers multiple dental plans, please review the options with your employer.

Name of Employer: ______________________________

Your Work Address: ______________________________

SECTION A – EMPLOYEE INFORMATION

Employee's Name: ______________________________
Last *First* *MI*

Employee's Address: ______________________________
Street *City* *State* *Zip*

Home Phone: (_______)______________ Best Time to Call: a.m. p.m. Work Phone: (_______)______________ Best Time to Call: a.m. p.m.

E-mail Address: ______________ Are you a U.S. Citizen? ☐ Yes ☐ No Are you a legal resident? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married (Date of Legal Marriage: ____________) ☐ Divorced (Date of Legal Divorce: ____________)

Full-time Employment Date: ____/ _____ / _____ Occupation/Job Duties: ______________________

Hours worked per week for this employer: ________________ Monthly Earnings: $________________

Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission **Employee Status:** ☐ W2 ☐ 1099 ☐ Owner/Partner ☐ Other *(specify)*:

Current Status: ☐ Currently Working ☐ COBRA ☐ Continuation ☐ Disability ☐ Retired ☐ Other Leave__________________

Effective Date of COBRA/Continuation or Other Leave *(MM/DD/YYYY)*: ____ / _____ / ______

SECTION B (Only to be completed by additions to existing groups or for changes to existing coverage.)

Group #: ______________________ Requested effective date: ____/____/____ (Subject to Underwriting approval)

This enrollment is for *(check one)*: ☐ New Enrollee ☐ Coverage Change *(specify)* ☐ Adding Spouse ☐ Adding Dependent Coverage

☐ Other Change *(specify type)*: ______________________ *# of Children:* ___________

Groups with multiple dental plans, indicate which plan you are requesting.* Dental Plan #: ______________________

**Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

SECTION C – COVERAGE REQUESTED

DENTAL: ☐ None** ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children

*** If waiving coverage on yourself, and/or your dependents, please fully complete the* ***Waiver of Coverage*** *in* **SECTION E** *of this enrollment form.*

SECTION D – PERSON(S) TO BE COVERED

(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet.)

Last Name	First Name	Relationship & Gender	Date of Birth (MM/DD/YYYY)	State of Birth	Social Security Number	Full-Time Student (age 19+)
		Employee ☐ M ☐ F				
		Spouse ☐ M ☐ F				
		Child ☐ M ☐ F				☐ Yes ☐ No
		Child ☐ M ☐ F				☐ Yes ☐ No
		Child ☐ M ☐ F				☐ Yes ☐ No

Please explain if any child listed above is (a) not your natural child, legally adopted child or stepchild, (b) not solely supported by you, or (c) not permanently residing in your household. ______________________

Assurant Health is the brand name for products underwritten and issued by John Alden Life Insurance Company.

SECTION E — WAIVER OF COVERAGE (Complete and sign if waiving dental coverages for self and/or dependents.)

All eligible employees and dependents must be listed as either enrolling or waiving coverage when first eligible. If you or any of your eligible dependents do not enroll in John Alden dental coverage when it is first made available and want to enroll in the future, your coverage may be subject to an extended waiting period for certain benefits. For further information on the late addition policy for group employers in your state, please contact your agent or a John Alden representative.

Person(s) Waiving	Other Coverage(s)	Carrier Name(s)	ID No.(s)	Effective Date(s)
☐ **Employee**	☐ Yes ☐ No			
☐ **Spouse**	☐ Yes ☐ No			
☐ **Child(ren)**	☐ Yes ☐ No			

Indicate the type of coverage in effect and for whom.

Type of Coverage	For Whom?		
☐ **Spouse's Employer Plan**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **COBRA**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Other, explain:**	☐ Employee	☐ Spouse	☐ Child(ren)

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or John Alden Life Insurance Company. I and my dependents have waived such coverage of our own accord.

Signature: ______________________________ **Date of Signature:** ____________

Printed Name: ______________________________ **Date of Full-time Employment:** ____________

SECTION F — PRIOR INSURANCE COVERAGE INFORMATION

1. Have you and all dependents you are enrolling been covered by this employer's dental plan(s) for the past 12 months? .... ☐ Yes ☐ No
2. Have you, your spouse or dependent children been covered by a dental plan within the last 12 months?....................................... ☐ Yes ☐ No
   If "Yes," was orthodontic treatment included? .... ☐ Yes ☐ No

Covered Persons	Insurance Company Name and Policy #	Effective Date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)	Reason for Termination
☐ Employee ☐ Spouse ☐ Child				
☐ Employee ☐ Spouse ☐ Child				

Will any current dental plan remain active if coverage is approved? ☐ Yes ☐ No If "Yes," for whom? ______________________

SECTION G — AUTHORIZATION AND SIGNATURE (Required if enrolling for dental coverage for self and/or dependents.)

I hereby represent that I am an employee of the participating employer and that the statements and answers to the questions on this enrollment form are true and complete to the best of my knowledge and belief. I understand that the statements and answers contained herein will be used by John Alden Life 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) any material misrepresentation or failure to provide complete information to questions on this enrollment form may be used as a basis for changing rates or terminating my coverage; (3) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (4) if I, my spouse and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility may be required and benefits may be deferred for a specified period of time; and (5) coverage will not be effective until I receive notice that this enrollment form has been approved by John Alden Life Insurance Company.

Information regarding your eligibility will be treated as confidential. All information received by John Alden Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I agree that a copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable John Alden Life Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for John Alden Life Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, John Alden Life Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying John Alden Life Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if John Alden Life Insurance Company has taken action in reliance on the authorization. I understand that Assurant Health markets products underwritten and issued by John Alden Life Insurance Company and that all references to John Alden Life Insurance Company in this authorization also includes Assurant Health.

This authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or if insured, when I am no longer an insured of John Alden Life Insurance Company, but in no event will this authorization be in effect for longer than 24 months from date signed.

Any person who knowingly and with intent to defraud any insurance company or other person submits an enrollment form for insurance or a statement of claim 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 understand that the agent submitting this enrollment form represents my interests, not those of John Alden Life Insurance Company. The agent has no right to bind coverage, to alter the terms of insurance coverage or enrollment form in any manner, or to adjust any claim for benefits. I, or my personal representative, have a right to receive a copy of this enrollment form.

This coverage provides dental benefits only. Review your Certification of Insurance carefully.

Signature of Employee ______________________________ **Date** ____________________

PLEASE NOTE: 1) John Alden Life Insurance Company is not responsible for enrollment forms not sent to us in a timely manner. 2) Effective dates are subject to underwriting approval. 3) Please retain a copy for your records.