

Group # A50112

PLEASE PRINT

GROUP DENTAL BENEFIT PLAN ENROLLMENT FORM

EMPLOYER			OCCUPATION			DEPT			LOCATION			DATE EMPLOYED / /					
SOCIAL SECURITY #			LAST NAME			FIRST MI			SEX <input type="checkbox"/> M <input type="checkbox"/> F			BIRTH DATE / /			EMPLOYEE PHONE # ()		
EMPLOYEE'S HOME ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP)																	

MARITAL STATUS: (CHECK APPROPRIATE BOX(ES) AND FURNISH DATE) NEVER MARRIED MARRIED ___/___/___ WIDOWED ___/___/___
 LEGAL SEPARATION ___/___/___ DIVORCED* ___/___/___ REMARRIAGE ___/___/___

* IF EVER DIVORCED AND ENROLLING DEPENDENTS, PLEASE PROVIDE A COPY OF ANY DIVORCE DECREE(S) REFERRING TO CUSTODY AND RESPONSIBILITY FOR HEALTH EXPENSES OF ANY DEPENDENTS DIRECTLY TO CoreSource, Inc. BE SURE TO INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND EMPLOYER NAME WITH THE DECREE. ELIGIBILITY FOR YOUR DEPENDENTS CANNOT BE DETERMINED AND CLAIMS WILL NOT BE CONSIDERED FOR PAYMENT UNTIL YOU HAVE RETURNED THE REQUESTED INFORMATION.

TYPE OF COVERAGE: (CHECK ONE) INDIVIDUAL (EMPLOYEE ONLY) EMPLOYEE PLUS ONE EMPLOYEE PLUS TWO
 FAMILY (EMPLOYEE & ELIGIBLE DEPENDENTS) NO COVERAGE

IF NO COVERAGE HAS BEEN SELECTED, I HEREBY REFUSE THE BENEFIT PLAN OFFERED BY MY EMPLOYER AND UNDERSTAND THAT MY FUTURE ENROLLMENT MAY BE SUBJECT TO CERTAIN RESTRICTIONS OR REQUIREMENTS AS DEFINED BY THE PLAN.

IS YOUR SPOUSE EMPLOYED? CHECK: YES NO
NAME, ADDRESS AND PHONE #
OF SPOUSE'S EMPLOYER

ARE YOU, YOUR SPOUSE OR DEPENDENTS COVERED UNDER ANY OTHER DENTAL PLAN? IF YES, WHO IS COVERED, PLAN NAME, NAME & ADDRESS OF INSURANCE CO., EFFECTIVE DATE OF COVERAGE
CHECK: YES NO

LIST OF DEPENDENTS:							CHECK YES OR NO FOR THESE QUESTIONS		
FIRST NAME	MI	(IF DIFFERENT) LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M/F	RELATIONSHIP (SEE KEY ON BACK)	DEPENDENT RESIDES WITH YOU?	YOUR IRS DEPENDENT?	ARE YOUR FINANCIALLY RESPONSIBLE?
DEP. #1						SPOUSE			
DEP. #2							Y N	Y N	Y N
DEP. #3							Y N	Y N	Y N
DEP. #4							Y N	Y N	Y N
DEP. #5							Y N	Y N	Y N

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS FRAUD WHICH IS A CRIME.

I HEREBY CONSENT AND AUTHORIZE ANY DENTIST, PHYSICIAN, SUPPLIER, HOSPITAL, PHARMACY, INSURANCE COMPANY, EMPLOYER OR ORGANIZATION TO DISCLOSE ANY INFORMATION REGARDING THE MEDICAL RECORDS CONCERNING MYSELF OR A MEMBER OF MY FAMILY TO CoreSource, Inc. FOR THE PURPOSE OF SUPERVISING AND MONITORING THE HEALTH PLAN(S). THIS CONSENT SHALL BE VALID UNTIL REVOKED IN WRITING BY THE EMPLOYEE.

EMPLOYEE SIGNATURE

DATE

TO BE COMPLETED BY EMPLOYER

EFFECTIVE DATE _____

<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> RE-ENROLLMENT	<input type="checkbox"/> NAME CHANGE - FORMERLY _____
<input type="checkbox"/> REINSTATEMENT	<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> CHANGE DEPENDENT STATUS:
<input type="checkbox"/> CANCELLATION	<input type="checkbox"/> ADDRESS CHANGE	REASON: _____
		DATE CHANGE OCCURRED: _____