☐ *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*

- ☐ Employee Only
- ☐ Employee+ Family
- ☐ Dental 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:**_____