



ENROLLMENT APPLICATION – SUBSCRIBER
PRINT LEGIBLY WITH PEN – ITEMS WITH * ARE REQUIRED

EMPLOYER GROUP

*Group Name: <i>Vanderburgh County</i>		Group Number: <i>919910729200</i>	*DHO Plan:
*Employee Location/Subgroup Name:	Employee Position:	*Group Phone No:	Plan Tier:

SUBSCRIBER

OPEN ENROLLMENT: Date: <input type="checkbox"/> ADD <input type="checkbox"/> TERM	HIRE: Date: <input type="checkbox"/> ELECT: I elect coverage for myself. <input type="checkbox"/> ELECT: I elect coverage for myself and dependent(s) LISTED below. <input type="checkbox"/> DECLINE: I decline coverage for myself and other dependent(s).	QUALIFYING EVENT: Date: <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Married Termination of Employment: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary				
*Last Name	*First Name	*MI	*Gender	*Date of Birth	*Member No. Is your Social Security #	*Hire Date
Employee:			<input type="checkbox"/> M <input type="checkbox"/> F			
Contact Information: *Mailing Address *Phone and Email	*Street and City:	*State:	*Zip:	*County:		
	*Phone No:	Email:				
*Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced					

*** COVERED DEPENDENTS – required if electing or terming coverage. If terming a dependent please choose an event below.**

ADD or TERM	Last Name	First Name	MI	Gender	Date of Birth	Member No. Social Security #	Qualifying REQUIRED DOCUMENTATION	Other Dental Coverage
Spouse: <input type="checkbox"/> Add <input type="checkbox"/> Term				<input type="checkbox"/> M <input type="checkbox"/> F			N/A	Carrier Name:
Dependent: <input type="checkbox"/> Add <input type="checkbox"/> Term				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Physical Disability <input type="checkbox"/> Full Time Student <input type="checkbox"/> Court Order	Guardian Birth Date: Carrier Name:
Dependent: <input type="checkbox"/> Add <input type="checkbox"/> Term				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Physical Disability <input type="checkbox"/> Full Time Student <input type="checkbox"/> Court Order	Guardian Birth Date: Carrier Name:
Dependent: <input type="checkbox"/> Add <input type="checkbox"/> Term				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Physical Disability <input type="checkbox"/> Full Time Student <input type="checkbox"/> Court Order	Guardian Birth Date: Carrier Name:
Dependent: <input type="checkbox"/> Add <input type="checkbox"/> Term				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Physical Disability <input type="checkbox"/> Full Time Student <input type="checkbox"/> Court Order	Guardian Birth Date: Carrier Name:

TERMING A DEPENDENT: Death Dependent Age Limit Divorce Gained other coverage Marriage Military Leave No Longer a FTS

QUALIFYING REQUIRED DOCUMENTATION: if you have checked any of the above boxes that apply:

Physical Disability: Requires statement from physician for coverage dependents only.	Full Time Student: Requires schedule or transcript from the educational institution showing full time status	Marriage/Divorce/Court Order: Requires marriage certificate, divorce decree, court order that states dependent responsibility.	Guardianship Papers: Required for dependents other than biological children or step-children.
---	---	---	--

SIGNATURE, RELEASE AND ASSIGNMENT:

By submitting this application, subscriber understands that coverage may not change until next open enrollment period, including coverage on dependents unless there is a change in family status. If coverage is approved and issued, subscriber authorizes Health Resources, Inc. (HRI), to make payment of any benefits directly to the dentist as the supplier of services rendered. Subscriber understands that the dentist(s) chosen to use are independent contractors, and are not employees of HRI and authorizes the dentist to release to HRI any information regarding history, symptoms, treatment, examination results or diagnosis. Subscriber further authorizes HRI and the dentists providing services to transmit by any means any and all information regarding services performed for self and dependents enrolled under this plan as may be required for the payment or evaluation of claims. A photo copy of this authorization shall be considered as effective and valid as the original. Subscriber understands they have the right to receive a copy of this authorization.

If this application is accepted, the information herein is an integral part of the plan. 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 and will be reported.

Signature of Employee _____

Date _____