



ENROLLMENT APPLICATION – MEMBER
ALL INFORMATION IS REQUIRED IN ORDER TO COMPLETE ENROLLMENT OR MAKE CHANGES

Member(EMPLOYEE) Social Security Number:		Site Location:		Group Legal Name : Vanderburgh County				
DHO Plan: <input type="checkbox"/> ELECT: Employee <input type="checkbox"/> ELECT: Employee and Spouse <input type="checkbox"/> ELECT: Employee and Child(ren) <input type="checkbox"/> ELECT: Family		<input type="checkbox"/> ADD New Enrollment <input type="checkbox"/> CANCEL Coverage <input type="checkbox"/> CHANGE to Coverage Qualifying Event Date: MM/DD/YYYY		QUALIFYING EVENT: <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Coverage-Gained <input type="checkbox"/> Coverage-Loss <input type="checkbox"/> Death <input type="checkbox"/> Divorced or Legal Separation <input type="checkbox"/> Married <input type="checkbox"/> New Employee <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Over Age Limit <input type="checkbox"/> Personal Information Update <input type="checkbox"/> Term-Involuntary <input type="checkbox"/> Term-Voluntary			Employee Hire Date: MM/DD/YYYY <input type="checkbox"/> Hourly <input type="checkbox"/> Salary	
<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change <input type="checkbox"/> DECLINE: I decline coverage for myself and dependent(s)	EMPLOYEE Last Name		First Name		MI	Gender	Birth Date	Relationship to Member SELF
	Mailing Address				City		State	Zip
	Email				Home Telephone		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced or Legal Sep.	
<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SPOUSE Last Name		First Name		MI	Gender	Birth Date	Relationship to Member SPOUSE
	Social Security Number		Other Dental Coverage					
<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	DEPENDENT Last Name		First Name		MI	Gender	Birth Date	Relationship to Member DEPENDENT
	Social Security Number		Other Dental Coverage and Guardian Birth Date					<input type="checkbox"/> Physical Disability <input type="checkbox"/> Full Time Student <input type="checkbox"/> Court Order
<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	DEPENDENT Last Name		First Name		MI	Gender	Birth Date	Relationship to Member DEPENDENT
	Social Security Number		Other Dental Coverage and Guardian Birth Date					<input type="checkbox"/> Physical Disability <input type="checkbox"/> Full Time Student <input type="checkbox"/> Court Order
<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	DEPENDENT Last Name		First Name		MI	Gender	Birth Date	Relationship to Member DEPENDENT
	Social Security Number		Other Dental Coverage and Guardian Birth Date					<input type="checkbox"/> Physical Disability <input type="checkbox"/> Full Time Student <input type="checkbox"/> Court Order

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: An over-age dependent, if full-time student, school schedule may be required. Contact employer's benefits administrator for submission procedure.	Marriage/Divorce/Legal Sep./Court Order: Requires marriage certificate, divorce decree, legal separation agreement, court order that states dependent responsibility.	Guardianship Papers: Required for dependents other than biological children or step-children.
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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 _____

Signature of Employer Benefits Administrator/Authorized Agent _____ Date _____

BA SIGNATURE NOT REQUIRED IF MEMBER APPLICATION IS SUBMITTED WITH EMPLOYER APPLICATION