HealthEdge ADMINISTRATORS

SelectDent / Select Vision

Employee Enrollment Form

Select Your Dental Plan(s) Dental Policy GH-1112-34740

Group Plans:	Voluntary Plans:	Voluntary Plans w/Ortho:	Group #
☐ Silver ☐ Gold ☐ Platinum	☐ Standard ☐ Deluxe ☐ Deluxe Plus	☐ Deluxe ☐ Deluxe Plus	

Select Your Vision Plan(s) Vision Policy Form GHA-1157

Group Plans:	Voluntary Plans:	Effective Date:
☐ Silver ☐ Gold ☐ Platinum	☐ Silver ☐ Gold ☐ Platinum	

Employee Information

☐ New Enrollment ☐ Annual Enrollment ☐ Change ☐ Termination ☐ COBRA Election ☐ Waived ☐ Other

Employer: _____ Job Title: _____

Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____ Date of Hire: _____

City, State, Zip: _____ Phone Number: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Dependent Information

Please list all dependents you cover, and check the coverage boxes that apply. Attach an additional sheet of paper if necessary.

Add / Delete	Dental or Vision	Name	Gender	Date of Birth	Relationship	SSN	Is Enrolling Child Currently Married
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Other Insurance

If you or your dependents are currently covered under any other insurance, please list below. Attach an additional sheet of paper if necessary.

Name	Carrier	Group #	ID #	Phone #

Previous Insurance

If you or your dependents have been covered under any other group insurance in the last twelve (12) months, please list below.

Name	Carrier	Group #	Effective Date	Termination Date

I understand (if selected) that I have made an election for coverage under Group Dental Insurance Policy Form GH-1112(97) issued to the Employers' Voluntary Benefit Insurance Trust for the _____ plan year and if selected under Group Vision Policy GH-1157 issued to the Group Policyholder insured by Security Life Insurance Company of America, Minnetonka, Minnesota and agree that the information provided by me is accurate and that any dependent information provided is subject to the eligibility provisions of the plan documents.

- I hereby authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This also authorizes my employer to make this payment on by behalf in lieu of my receiving a taxable cash benefit equal to this amount.
- I hereby authorize any health care provider to release any information regarding the dental history, treatment or benefits payable, to HealthEdge Administrators, Inc. and its affiliates or its authorized agent for the purpose of validating and determining benefits payable in connection with these plans.
- I authorize the collection and/or filing of a lawsuit for recovery of monies paid for benefits when a third party is responsible for the injuries or illnesses.
- I understand the benefit elections I have made on this form may only be altered due to a special enrollment right or change in status as defined and permitted under the plan. I understand that if I decline any coverage – other than health coverage – and apply at a later date, I may be required to show evidence of insurability.
- I understand that inaccurate information provided by me could result in the denial of benefits.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misdealing, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal penalties *(not enforceable in OR or VA).*
- California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
- The employee must sign in all cases. Each person signing below declares that all the information given in this enrollment form is true and completes to the best of his/her knowledge and belief.

Employee Signature: **Date:**

Printed Name: