**PASSIVE**
**GROUP DENTAL ENROLLMENT FORM**

**First Continental Life & Accident Insurance Company**
12946 Dairy Ashford Suite 360 Sugar Land, TX 77478 TEL: (877)493-6282

| Name of Employer (Use Name from Group Billing Notice or Master Application) | Group Number | DIV | CLASS |
|---|---|---|---|
| | | | |

## To Be Completed by All Employees

| **Social Security number** | **Effective Date** Month / Day / Year / / | **Date Employed Fulltime** Month / Day / Year / / | **Hours Worked per Week** |
|---|---|---|---|
| | | | |

| **Your Name** (Last), (First), (Middle Initial0 | **Date of Birth** Month / Day / Year / / | **Sex** Male ☐ Female ☐ |
|---|---|---|
| | | |

| **Home Phone:** | **Work Phone:** |
|---|---|
| | |

**Home Address:**
_____
_____
_____

**Coverage Requested**

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

Do you have any other Dental coverage? If so, Carrier _____

## (Complete for Dependent Coverage)

| | **Spouse Name** (Last), (First), (Middle Initial) | | **DOB** | **Do any of your dependents have any other dental coverage?** | **If so, Name of Carrier** |
|---|---|---|---|---|---|
| | | **M or F** | / / | ☐ Yes ☐ No | |
| 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 material 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 it 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:** _____