

# Employee Enrollment Card



## BEST LIFE and Health Insurance Dental Enrollment Card

Please indicate which plan you desire below:

**Incentive Plan**

**Open Choice**

Company Name <b>Ascend HR</b>				Date of Full Time Employment / /			Basic Monthly Wage <b>N/A</b>			
Employee Name – Last				First			Middle			
Your Home Address				City		State	Zip	Social Security Number - -		
Date of Birth / /	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	No. of Eligible Dependents	Marital Status <input type="checkbox"/> Not Married <input type="checkbox"/> Married		Job Title				
For Office Use Only	Waiver		Cobra		EE _____ 1 = Employee 2 = Dependent 3 = EE & Dependent	DEP. Refusal _____ R = No Coverage O = Other Coverage		Spouse EE <b>Y / N</b>	COB <b>Y / N</b>	Dep 19+ FTS Y H Y
Eff. Date / /	ER#	Coverages	Prev <b>EE/Dep</b>	New Chg	WP	#EES	Late <b>L</b>	Newborn <b>N</b>	APP = A Decl = D	Initials

I agree that insurance does not begin until this application is approved by Best Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid.

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### Dependent Information

Are you insuring your dependents?  Yes  No. If 'Yes', please complete the section below. If enrolling dependent children between the ages of 21 and 25, please indicate if they are a full time student.

Dependent Name	Relationship	Full Time Student	Sex	Date of Birth
		<b>Yes/No</b>	<b>Male/Female</b>	/ /
		<b>Yes/No</b>	<b>Male/Female</b>	/ /
		<b>Yes/No</b>	<b>Male/Female</b>	/ /
		<b>Yes/No</b>	<b>Male/Female</b>	/ /
		<b>Yes/No</b>	<b>Male/Female</b>	/ /

Do you, your spouse or child have any other dental insurance?  Yes  No. If 'Yes', please complete the section below.

Policyholder (Name) \_\_\_\_\_ Policy Number \_\_\_\_\_ Name and Address of Insurance Carrier \_\_\_\_\_

I certify that my date of birth, date of employment and other information on this form are correct and that I am working at the employer's place of business in full time employment at least 30 hours per week. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on each certificate of insurance issued to me; however, if I am absent from full-time employment on such dates as the result of an accident or sickness I agree that coverage is not effective. I determine the coverage in force and that a coverage is not in force if an application for that coverage has not been made by my employer.

Additionally, if I am accepted, this request for group insurance will become part of the agreement between BEST LIFE and Health Company and myself. I, and any enrolled family members, agree to be bound by the arbitration clause in the BEST LIFE and Health Insurance *Certification Booklet* instead of trial by a court of jury.

I agree that insurance does not begin until this application is approved by Best Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid.

Your Signature in black ink	Date <span style="float: right;">DECform0925</span>
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**Reverse side must be completed**

EEForm0925