

## GROUP DENTAL ENROLLMENT FORM

<input type="checkbox"/> New Employee	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Change Dependent	<input type="checkbox"/> Address Change	<input type="checkbox"/> Cancel Coverage
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<b>Name of Employer:</b> (Use Name from Group Billing Notice or Master Application) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">ASCEND HR SOLUTIONS</div>	<b>Group Number:</b> CQJ UTH25940	<b>Div:</b>	<b>Class:</b>
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**Plan Types:**

PPO Plan \_\_\_\_\_ HMO Plan \_\_\_\_\_

<u>Social Security Number</u>	<u>Effective Date</u> Month / Day / Year	<u>Date Employed Fulltime</u> Month / Day / Year	<u>Hours Worked Per Week</u>
<b>Your Name</b> (Last), _____ (First), _____ (MI) _____		<b>Date of Birth</b> Month / Day / Year	<b>Sex:</b> Male: <input type="checkbox"/> Female: <input type="checkbox"/>

<b>Home Address:</b> _____ _____ _____ Home Phone Number: _____ Work Phone Number: _____ Do you have any other Dental coverage? If so, Carrier _____	<b>Coverage Requested:</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2 <input type="checkbox"/> Employee + 3 or more
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Complete for Dependent Coverage:			Do any of your dependents have any other dental coverage?	
<b>Spouse Name:</b> (Last), _____ (First), _____ (MI) _____	<b>Date of Birth:</b>			<b>If so, Name of Carrier:</b>
<b>Sex:</b>	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHILDREN	1.	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2.	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3.	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4.	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5.	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	6.	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Fraud Warning** (Not Applicable in AZ): 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 a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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:** \_\_\_\_\_

Underwritten by: COMPANION LIFE INSURANCE COMPANY  
 Columbia, South Carolina

Return To:  
**Total Dental Administrators, Inc.**  
 2111 East Highland Avenue, Suite B-425  
 Phoenix, AZ 85016-4735  
 1-888-422-1995

10/1/2003