

Employee Enrollment / Change Form

Use this form for new enrollment or a change to an existing enrollment. Mail to above address or fax to (877) 648-7748

Please print in blue or black ink.

Group Number: _____

Effective Date of Enrollment/Change: _____

Enrollment Form is for:

- Dental Coverage Only
 Dental & Life Insurance Coverage
 Life Coverage Only

Reason for Enrollment Form

- | | |
|---|---|
| <input type="checkbox"/> New Enrollment/New Hire
<input type="checkbox"/> Qualifying Event (<i>Attach supporting documentation</i>)
<input type="checkbox"/> Late Enrollee (<i>Subject to Late Enrollee Waiting Period</i>)
<input type="checkbox"/> Add Dependent:
Marriage (<i>Date of Marriage: _____</i>)
Birth/Adoption (<i>Date of Birth/Adoption: _____</i>)
Other (<i>Specify: _____</i>) | <input type="checkbox"/> Change of Address
<input type="checkbox"/> Terminate Dental Coverage, Subscriber & Dependent(s)
<input type="checkbox"/> Terminate Dental Coverage, Dependent(s) Only
<input type="checkbox"/> Terminate Life Insurance Coverage
<input type="checkbox"/> Change in Other Dental Insurance (<i>Please see reverse side</i>)
<input type="checkbox"/> Change Life Insurance Beneficiary (<i>Please see reverse side</i>)
<input type="checkbox"/> Other (<i>Specify: _____</i>) |
|---|---|

Subscriber (Employee) Information

Social Security Number: _____ Date of Hire: _____
 Last Name: _____ First Name: _____ MI: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: (_____) _____ E-mail Address: _____
 Date of Birth: _____ Sex: M F Married? Yes No Children? Yes No
 Employer (Company) Name: _____
 Job Title: _____ Division/Class: _____ Hours Worked Per Week: _____

Dependent Information *New Enrollment/New Hire:* Complete this section for all dependents you are choosing to enroll.
Add Dependent: Complete this section only for the dependents you are adding to your existing enrollment.
Terminate Dependent Coverage Only: Complete this section only for dependent(s) you are choosing to terminate.

Relation to Subscriber	Last Name	First Name & MI	Date of Birth	Sex (M/F)	If dependent is age 19 or over, check the applicable box. Attach supporting documentation.***	
					Age 19 or over and under 24, full-time student or IRS dependent	Age 19 or over, disabled and fully supported
Spouse						
Child					<input type="checkbox"/>	<input type="checkbox"/>
Child					<input type="checkbox"/>	<input type="checkbox"/>
Child					<input type="checkbox"/>	<input type="checkbox"/>
Child					<input type="checkbox"/>	<input type="checkbox"/>

Other Dental Coverage

Do you or your dependents have other dental coverage? Yes No (*If yes, complete the information on reverse.*)

Life Insurance Coverage

Is Life Insurance being elected? Yes No (*If yes, complete Benefit and Beneficiary information on reverse.*)

I certify that the information on this application, including the information on the back of this application is true and complete. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment application. I have read and agree to the notice on the back of this form.

Employee Signature: _____ Date: _____

*** If supporting documentation is not attached with this form, Premier will be unable to process claims for the dependent.

Other Dental Coverage Information

Name of Insured: _____ Social Security Number: _____
 Insured's Employer: _____ Name of Insurance Carrier: _____
 Employer's Street Address: _____
 City: _____ State: _____ Zip: _____ Phone: (____) _____
 Are your dependent children enrolled under your spouse's dental plan? Yes No

Life Insurance Benefits – Coverage Elected: (If coverage is elected, complete beneficiary information below.)

Employee		Dependent(s)	
Amount	Amount	Amount	Amount
<input type="checkbox"/> Basic Life \$ _____	<input type="checkbox"/> Supplemental Life \$ _____	<input type="checkbox"/> Spouse Life \$ _____	<input type="checkbox"/> Spouse Supplemental Life \$ _____
<input type="checkbox"/> Basic AD&D \$ _____	<input type="checkbox"/> Supplemental AD&D \$ _____	<input type="checkbox"/> Spouse AD&D \$ _____	<input type="checkbox"/> Spouse Supplemental AD&D \$ _____
<input type="checkbox"/> STD \$ _____	<input type="checkbox"/> LTD Buy-up Option \$ _____	<input type="checkbox"/> Child Life \$ _____	<input type="checkbox"/> Child Supplemental Life \$ _____
<input type="checkbox"/> LTD \$ _____	<input type="checkbox"/> Other _____ \$ _____	<input type="checkbox"/> Child AD&D \$ _____	<input type="checkbox"/> Child Supplemental AD&D \$ _____

Life Insurance Beneficiary Information

Note: The primary beneficiary(ies) will receive your life insurance benefits. If the primary beneficiary(ies) is no longer living, the secondary beneficiary(ies) will receive the benefits.

Last Name, First Name MI	Social Security #	Address	Date of Birth	Relationship	Designation
					<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
					<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

I, on my behalf and on behalf of my dependent(s) on this enrollment application, hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance, or agree that the contributions be added to my dues; (3) state that I became a full-time employee on the date stated on the reverse, and do currently work the number of hours per week stated on the reverse, (4) agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Premier* Certificate of Insurance, (5) agree that if I or my dependents receive dental services after my coverage is terminated or lapses, that I am responsible to reimburse Premier for any unrecovered payments made by Premier for such services, and (6) understand that verification of eligibility by Premier does not guarantee payment of claims and that retroactive eligibility changes supercede verifications of eligibility.

MANDATORY BINDING ARBITRATION: I understand that in the event a dispute arises between myself, and/or my Dependent(s), and Premier, the same shall be settled by neutral, binding arbitration as set out in the Premier Certificate of Insurance. This does not relate to your life coverage.

DENTAL RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby authorize Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. This authorization shall remain in effect for the term of my and my Dependent(s) enrollment.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage or by the act or omission of another person, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided. I further agree that in the event I or any of my Dependent(s) collect benefits or damages from any other party who has primary responsibility for services provided by Premier, I will immediately reimburse Premier to the extent of services and supplies received.

LIFE INSURANCE: If I have elected life insurance benefits, I hereby request coverage for myself and any eligible dependents as listed on this form and authorize my employer to deduct from my pay my contribution (if any) to the cost of coverage. I certify that the dependent(s) listed are my dependent(s), as defined in the plan, and any change in dependent status will be reported to Premier and SAFECO**. I agree to be bound by all terms of the plan under which I am applying for coverage. I certify that to the best of my knowledge and belief, the information shown on this enrollment form is correct. I authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically-related facility, insurance company, the Medical Information Bureau, or other insurance support organization or institution, that has any records or knowledge of me or my dependents, as listed on this form, about my health or their health, to give SAFECO or its representatives or reinsurers, any such information and to testify as to such information, all to the extent permitted by law.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

* All references to "Premier" herein refer to Premier Access Insurance Company
 ** All references to "SAFECO" herein refer to SAFECO Life Insurance Company