# Group Dental/Vision Enrollment Form

motivhealth®

| | | | | |
|---|---|---|---|---|
| New Hire ☐ | Open Enrollment ☐ | Change Plan ☐ | COBRA Enrollment ☐ | Cancel Coverage ☐ |
| Address/Name Change ☐ | Qualifying Life Event * Please obtain supporting documentation ☐ | Loss of Coverage ☐ | Dependent Add/Delete ☐ | * Complete enrollment form in its entirety. Unlisted dependents will be termed by omission |

**Name of Employer**

| | | | |
|---|---|---|---|
| **Dental PPO** ☐ | **VISION** ☐ | **WAIVE VISION (sign below)** ☐ | **WAIVE DENTAL (sign below)** ☐ |
| **Dental Plan Name** | **Vision Plan Name** | | |

| **Social Security Number** | **Effective Date** | **Date Employed Fulltime** | **Hours Worked Per Week** |
|---|---|---|---|
| | | | |

| **Your Name** | **Date of Birth** | **Sex** |
|---|---|---|
| (Last), (First), (MI), | | Male: ☐ Female: ☐ |

**Home Address**

(Address),

(City), (State), (ZIP),

**Phone Number**

Do you have other dental coverage? If so, carrier name:

**Coverage & Tier Type**

4 Tier — Dental & Vision

| | **Dental** | **Vision** |
|---|---|---|
| Employee Only | ☐ | ☐ |
| Employee + Spouse | ☐ | ☐ |
| Employee + Children | ☐ | ☐ |
| Employee + Family | ☐ | ☐ |

**Dependent Coverage**

| | | **Sex** | **Date of Birth** | Do any of your dependents have other dental coverage? If so, carrier name: |
|---|---|---|---|---|
| **Spouse Name** (Last), (First), (MI) | | Male: ☐ Female: ☐ | | **Yes** ☐ **No** ☐ |
| **CHILDREN** | **1.** | Male: ☐ Female: ☐ | | **Yes** ☐ **No** ☐ |
| | **2.** | Male: ☐ Female: ☐ | | **Yes** ☐ **No** ☐ |
| | **3.** | Male: ☐ Female: ☐ | | **Yes** ☐ **No** ☐ |
| | **4.** | Male: ☐ Female: ☐ | | **Yes** ☐ **No** ☐ |
| | **5.** | Male: ☐ Female: ☐ | | **Yes** ☐ **No** ☐ |
| | **6.** | Male: ☐ Female: ☐ | | **Yes** ☐ **No** ☐ |

**FRAUD WARNING** (Not Applicable in AZ, FL, GA, 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 and 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.

## *Authorization of Coverage/Change*

I elect the dental and/or vision 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.

**Signature** **Date**

## *Waive Coverage*

I have been offered this insurance coverage and decline all or part as indicated above.

**Signature** **Date**

***Qualifying Event Supporting Documentation**

Acceptable supporting documentation includes prior carrier letter, marriage license, divorce or separation decree, birth certificate, spouse employment status documents, spouse coverage status change, etc.

**Submit Form To:**
Group HR