DENTALSELECT

Utah Employee Enrollment Form

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8704 **DentalSelect.com**

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

Last Name	**First Name**		
Street Address			
City	**State**	**Zip Code**	
Home Phone	**Date of Birth** (MM/DD/YYYY)		
SSN	**Marital Status** ☐ Married ☐ Single	**Gender** ☐ Male ☐ Female	
Effective Date (MM/DD/YY)	**Date of Hire (Required)** (MM/DD/YY)		
Employer's Full Name Total Joint Orthopedics			
Employer's Address			
Group Number 12010412	**Subgroup/Dept. #**		

Coverage Selection - Confirm available options with your employer. Check all that apply.

Dental

☐ **PPO** - Platinum Network

Insured Vision

Access Choice:

☐ **Vis 6**

Individuals Covered - List individuals for whom you are enrolling.

Dental	Vision			Gender	SSN	Date of Birth - (MM/DD/YYYY)
☐ Enroll	☐ Enroll		**Spouse Name -** (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll		**Dependent Name -** (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll		**Dependent Name -** (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll		**Dependent Name -** (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll		**Dependent Name -** (Last, First, MI)	☐ Male ☐ Female		
☐ Enroll	☐ Enroll		**Dependent Name -** (Last, First, MI)	☐ Male ☐ Female		

For additional dependents include the Dependent Enrollment Form

Covered by other DENTAL Insurance? ☐ Yes ☐ No	**If Yes,** Name of other Dental Insurance Company	Name of Person Insured	Social Security Number

Confirmation for Dental and Vision Insurance Coverage

Authorization ☐ Check here to waive if no coverage is desired ☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, that I will not be entitled to any compensation for my non-participation. I further understand I will not be eligible to enroll in this plan again until next enrollment period.

Signature (Required) _____ Date _____