Direct Reimbursement Dental/Vision Plan Enrollment Form

Name of Company: _____ I am enrolling in ❑Dental ❑Vision

Coverage Elected: ❑Employee ❑Employee & Spouse ❑Employee & Children ❑Family

Name of Employee: _____Date of Birth: _____

Address:_____City_____State_____Zip_____

SS#: _____Home Phone:_____

Complete this section only if you are electing dependent coverage

Spouse's Name: _____ Date of Birth: _____

Dependent Children

Name	**Date of Birth**	**Relationship**

I hereby apply for dental/vision benefits under my employer's plan. I am aware that:

1. I am enrolling for coverage now and realize I cannot change my election until the next enrollment period unless there is a change in family status.
2. I hereby authorize my contributions to the plan, if applicable, be withheld from my paycheck.

By my signature below, I represent that all information shown on this form is correct.

_____ _____

Signature of Employee Date

Employer must complete

Date of Hire _____Effective Date of Coverage _____ Late Applicant? ❒ Yes ❒ No

Refusal Of Coverage

I was given a chance to enroll in the Direct Reimbursement Dental Plan sponsored by my employer. I am refusing coverage for myself and all dependents. I understand that by refusing coverage, I cannot change this election until the next open enrollment.

_____ _____

Employee Signature Date