dental health OPTIONS® by Health Resources, Inc.

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ENROLLMENT APPLICATION – SUBSCRIBER

ALL INFORMATION IS REQUIRED IN ORDER TO COMPLETE ENROLLMENT, MAKE CHANGES AND PROCESS CLAIMS

Group Legal Name :	Group Number:	Site Location:	DHO Plan:

Coverage Election:
- ☐ Employee ONLY
- ☐ Employee and Spouse/Partner
- ☐ Employee and One Dependent
- ☐ Employee and Dependents
- ☐ Employee Spouse/Partner & Dependent(s)

☐ **Decline**: I decline coverage for myself & dependent(s)

☐ **OPEN ENROLLMENT:**
- ☐ Subscriber Declining Coverage for Upcoming Plan Year
- ☐ Subscriber Terminating Dependent Coverage for Upcoming Plan Year
- ☐ Coverage Gained
- ☐ Death
- ☐ Divorced or Legal Separation
- ☐ Married
- ☐ No Longer Full Time Student
- ☐ Over Age Limit

☐ **STATUS CHANGE:**
- ☐ Employment Term Involuntary
- ☐ Employment Term Voluntary
- ☐ Reduction Hours of Employment
- ☐ Coverage Gained
- ☐ Coverage Lost
- ☐ Death
- ☐ Divorced or Legal Separation
- ☐ Married
- ☐ No Longer Full Time Student
- ☐ Over Age Limit
- ☐ Plan Change

DATE (format): MM/DD/YYYY
Effective Date:
Date of Status Change:
Date of Employment Term:
Month Covered Through:
Coverage for Members is offered on a monthly basis to match premium billing.

COBRA:
Group Administration (If applicable)
- ☐ Term of COBRA coverage by Group
- ☐ Reinstatement of Subscriber
  Billing: ☐ Separate Group ☐ Site Location

Action Requested					
☐ Add ☐ Term ☐ Update Info	**EMPLOYEE (Subscriber)** Social Security Number:			Employee Hire Date: **MM/DD/YYYY** ☐ Hourly ☐ Salary	
	Last Name	First Name	MI	Birth Date	Relationship to Subscriber SELF
	Employee Home Address	City		State	Zip
	Email	Contact Phone Number		☐ Single ☐ Married ☐ Divorced or Legal Sep.	
	Employee Work Address	City		State	Zip

Action Requested					
☐ Add ☐ Term ☐ Update Info	**SPOUSE/PARTNER** Last Name	First Name	MI	Birth Date	Relationship to Subscriber SPOUSE/PARTNER
	Social Security Number	Other Dental Coverage			
	Spouse/Partner Home Address if Different than Subscriber	City		State	Zip

Action Requested					
☐ Add ☐ Term ☐ Update Info	**DEPENDENT** Last Name	First Name	MI	Birth Date	Relationship to Subscriber DEPENDENT
	Social Security Number	Other Dental Coverage and Guardian Birth Date			☐ Permanent Disability ☐ Full Time Student ☐ Court Order/Guardian
	Dependent Home Address if Different than Subscriber	City		State	Zip

Action Requested					
☐ Add ☐ Term ☐ Update Info	**DEPENDENT** Last Name	First Name	MI	Birth Date	Relationship to Subscriber DEPENDENT
	Social Security Number	Other Dental Coverage and Guardian Birth Date			☐ Permanent Disability ☐ Full Time Student ☐ Court Order/Guardian
	Dependent Home Address if Different than Subscriber	City		State	Zip

REQUIRED DOCUMENTATION: if you have checked any of the above boxes that apply:

Permanent Disability: Requires statement from physician for dependent(s) coverage only.	**Court Order:** Requires court order that states dependent responsibility, OR **Guardianship Papers:** Required for dependents other than adopted, biological or step-children.

SIGNATURE, RELEASE AND ASSIGNMENT:

By submitting this application, subscriber understands that coverage may not change until next open enrollment period, including coverage on dependents ***unless there is a change in family status.*** *If coverage is approved and issued, subscriber authorizes Health Resources, Inc. (HRI), to make payment of any benefits directly to the dentist as the supplier of services rendered. Subscriber understands that the dentist(s) chosen to use are independent contractors, and are not employees of HRI and authorizes the dentist to release to HRI any information regarding history, symptoms, treatment, examination results or diagnosis. Subscriber further authorizes HRI and the dentists providing services to transmit by any means any and all information regarding services performed for self and dependents enrolled under this plan as may be required for the payment or evaluation of claims. A photo copy of this authorization shall be considered as effective and valid as the original. Subscriber understands they have the right to receive a copy of this authorization.*

If this application is accepted, the information herein is an integral part of the plan. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 will be reported.

Signature of Employee_____ Date_____

Signature of Employer Benefits Administrator/Authorized Agent_____ Date_____

BENEFIT ADMIN SIGNATURE NOT REQUIRED IF SUBSCRIBER APPLICATION IS SUBMITTED WITH EMPLOYER APPLICATION or Renewal.

HRI_____