luminare health℠

Experience. Solutions. Results.

# DENTAL ENROLLMENT FORM

## Group Name: North Fork

| Subscriber Name | Subscriber SSN | Date of Birth | Gender |
|---|---|---|---|
| | | | |

| Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Occupation | Date Employed As Benefits Eligible | Hours Scheduled Per Pay |
|---|---|---|
| | | N/A |

***Reason for Enrollment (Must provide proof of dependent status for all enrollments)***

☐ Open Enrollment ☐ Initial Enrollment

☐ Enrollment change due to (please check appropriate box below and provide verification as indicated):

- ☐ Marriage (certificate)
- ☐ Divorce (court order)
- ☐ Court ordered coverage (court order)
- ☐ Other:
- ☐ Birth of a child (birth certificate)
- ☐ No longer meets eligibility requirements
- ☐ Adoption or placement for adoption (court order)
- ☐ Loss of other dental coverage (attach proof of loss of coverage)

| Benefit Options and Coverage Selection | |
|---|---|
| **Dental** | ☐ Decline<br>☐ Employee Only ☐ Family ☐ Not Used |

☐ Cancel

| Add Dependents- SPOUSE | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | | First Name | M/I | Gender M/F | | |
| | | | | | | |
| SSN (required) | DOB | Relationship | FT Student Over 18 Y/N | Foster/Step Child Y/N | Disabled Y/N | |
| | | | | | | |

Does this Spouse have access to other dental coverage through his or her employer? Please circle one: Yes / No

Is this Spouse covered under another dental plan?

(Circle one) Yes / No If yes, Name of Carrier:

| Add Dependents | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | | First Name | M/I | Gender M/F | | |
| | | | | | | |
| SSN (required) | DOB | Relationship | FT Student Over 18 Y/N | Foster/Step Child Y/N | Disabled Y/N | |
| | | | | | | |

Does this dependent have access to other dental coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another dental plan? (Circle Yes / No If yes, Name of Carrier:

| Add Dependents | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | | | First Name | | M/I | Gender M/F |
| | | | | | | |
| SSN (required) | DOB | Relationship | FT Student Over 18 Y/N | Foster/Step Child Y/N | | Disabled Y/N |
| | | | | | | |

Does this dependent have access to other dental coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another dental plan? (Circle one) Yes / No If yes, Name of Carrier:

## Employee Signature (Read and Sign Below)

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- I have read and understand my rights and Special Enrollment which are included with this enrollment form.
- My dependents, including step and foster children and those over the maximum age, are eligible for coverage based on plan provisions.
- If I decline the benefit options offered or do not complete and return this enrollment form I and/or my dependents may not enroll until the next Open Enrollment Period unless I experience a qualified change in family status. Changes in election due to a qualifying change in the family status must be made no later than 31 days after the date of the qualifying change in the status.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud by submitting an application, enrollment form, or filing a claim containing a false or deceptive statement may be guilty of fraud.

**I declare that the information I have completed on this enrollment form is complete and true.**

Signature: Date: