



• Please Print clearly and in Black or Blue ink • Please Print in Capital Letters only

ENROLLMENT/CHANGE FORM
DENTAL/VISION

Planholder Name (Company Name) Group Plan Number Division Class

CITY OF O'FALLON, ILLINOIS

395174

PLEASE CHECK APPROPRIATE BOX Initial Enrollment/Refusal of Coverage Add Employee/Dependents Drop/Refuse Coverage Information Change

SECTION 1: Add Employee, Add Spouse, Add Children, New Hire, Marriage Date, Previously refused this coverage, Adoption Date, Loss of Other Coverage. SECTION 2: Drop Employee, Drop Dependents, Termination of Employment, Retirement, Last Day of Coverage.

SECTION 3: SELECT COVERAGE(S): Dependents cannot be enrolled for coverage refused by the employee. Dental, Employee, Spouse, Child(ren), Indemnity, PPO, Buy-Up, Pre-Paid.

SECTION 4: REFUSE/DROP COVERAGE(S): (See Refusal on back) Dental, Employee, Spouse, Child(ren), Vision, Covered under another insurance plan, Other.

SECTION 5: LOSS OF OTHER COVERAGE: I and/or my dependents were previously covered under another group plan. Loss of coverage was due to: Termination of Employment, Divorce, Death of Spouse, Term./Expiration of Coverage.

SECTION 6: Employee Name, Street address, City, State, ZIP, Home Phone, Marital Status, Occupation/Job Title, Date of Full Time Hire. Spouse Name, Child Name, Student, Birth Date, Social Security Number.

A) Have you included stepchildren? B) Is this your first eligible child? Are they dependent upon you for support and maintenance? If "no," please list all eligible children above.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signature: Date (MM DD YYYY)