HRI DENTAL &VISION

insuringsmiles.com
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800-727-1444 Fax: 812-424-2096

ENROLLMENT APPLICATION

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

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

ADD	TERM	UPDATE
Coverage Effective Date: ________	Coverage Termination Date: ________	Event Date (if applicable): ________
☐ Open Enrollment	☐ Open Enrollment	☐ Name Change
☐ New Hire	☐ Employment Termination	☐ Social Security Number
☐ Coverage Lost	☐ Coverage Gained	☐ Date of Birth
☐ Marriage	☐ Death	☐ Address
☐ Divorced or Legal Separation	☐ Reduction of Hours Worked	☐ Coordination of Benefits
☐ Birth/Adoption	☐ Divorced or Legal Separation	☐ Disability
☐ COBRA (if applicable)	☐ Over Age Limit	☐ Full-Time Student Status
	☐ No Longer Full-Time Student	
	☐ COBRA (if applicable)	

EMPLOYEE

EMPLOYEE	PRODUCT	Social Security Number		Employee Hire Date	
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Last Name	First Name	MI	Birth Date
PREFERRED LANGUAGE		Home Address	City	State	Zip
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ________	Phone Number	Email Address		

SPOUSE / PARTNER

SPOUSE / PARTNER	PRODUCT	Social Security Number	Birth Date	☐ Disability ☐ Full-Time Student	Other Dental Coverage? ☐ Yes ☐ No
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No
PREFERRED LANGUAGE		Phone Number	Email Address		
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ________				

DEPENDENT

DEPENDENT	PRODUCT	Social Security Number	Birth Date	☐ Disability ☐ Full-Time Student	Other Dental Coverage? ☐ Yes ☐ No
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No
PREFERRED LANGUAGE		Phone Number	Email Address		
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ________				

DEPENDENT

DEPENDENT	PRODUCT	Social Security Number	Birth Date	☐ Disability ☐ Full-Time Student	Other Dental Coverage? ☐ Yes ☐ No
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No
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PREFERRED LANGUAGE		Phone Number	Email Address		
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ________				

Please sign and date second page.

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: 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.

For Iowa and Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer submits an application or files a claim containing a false deceptive statement is guilty of insurance fraud.

Employee_____ Date _____

Employer Benefits Administrator/Authorized Agent_____ Date _____