# ACCESS ENROLLMENT APPLICATION

Insured by CompBenefits Insurance Company, Roswell, Georgia

**ENROLLMENT INSTRUCTIONS:**

1. Complete the application. (Be sure to list all Family Members to be included)
2. Complete the authorization for deduction with full information and sign in the lower portion.
3. Return the completed application and authorization for deduction to your payroll department for processing.

| SOCIAL SECURITY # | LAST NAME | FIRST | MI | DATE OF BIRTH / / |
|---|---|---|---|---|
| | | | | |

| HOME ADDRESS | AREA CODE | HOME PHONE | SEX ☐M ☐F |
|---|---|---|---|
| | | | |

| CITY | STATE | ZIP CODE | AREA CODE | BUSINESS PHONE | EMAILADDRESS |
|---|---|---|---|---|---|
| | | | | | |

| NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION | OCCUPATION (TITLE) | DATE HIRED FULL TIME |
|---|---|---|
| | | |

**LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED**

| FIRST M.I. LAST | SOCIAL SECURITY # | SEX | BIRTHDATE |
|---|---|---|---|
| SPOUSE: | | ☐M ☐F | / / |
| CHILD: | | ☐M ☐F | / / |
| CHILD: | | ☐M ☐F | / / |
| CHILD: | | ☐M ☐F | / / |

| EFFECTIVE DATE | PLAN CODE | GROUP CODE # | PREMIUM AMOUNT $ | AMOUNT PAID $ | AGENT CODE |
|---|---|---|---|---|---|
| | | | | | |

**I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to CompBenefits for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care. Furthermore, I acknowledge that I have been informed of the following: 1) the number, mix and distribution of participating providers; 2) the existence of limitations and disclosure of such limitations on choices of health care providers; and 3) a summary of any agreements between the plan and the provider as they pertain to financial incentives or disincentives, if any.**

**Applicant's Signature:** _____ **Date:** _____

**Agent's Signature:** _____

**Please Note:**
Any person who, with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Completed applications, with correct premiums, received by the Home Office by the 15th of the month will become effective on the 1st of the following month.

**AUTHORIZATION FOR DEDUCTION** – Signature Required – Employer

Name: _____ Social Security #: _____

I authorize _____ To make a: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
(Employer, Financial, or other organization) Check correct payment method

Deductions of $ _____ From: My salary or other compensation,

and to remit the amount deducted to **CompBenefits (CB)**, upon instruction from **CB**. The amount of deduction indicated above is approximate and may be corrected as instructed by **CB**. This authorization shall cease (a) upon my giving written cancellation notice to you; or (b) automatically upon my termination as a member or depositor, as the case may be, of the above named organization. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **CB** and if this authorization terminates for any reason, any further payments required under said policy (ies) shall be made as provided in the policy (ies). I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for **CB**.

Applicants Signature: _____ Date Signed: _____