DUAL CHOICE ENROLLMENT APPLICATION

☐ CHOICE ONE - DHMO

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (Be sure to list all Family Members to be included.)
2. **Select a dental office from the Provider List and Insert the dental facility number on the application.**
3. Complete the authorization for deduction with full information and sign in the lower portion.
4. Return the completed application and authorization for deduction to your payroll department for processing.

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

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	DENTAL FACILITY #

NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION	EMAIL ADDRESS
Gulf Coast Regional Blood Center	

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

FIRST M.I. LAST	S.S.N. #	SEX	BIRTHDATE	DENTAL FACILITY #
SPOUSE:		☐M ☐F	/ /	
CHILD:		☐M ☐F	/ /	
CHILD:		☐M ☐F	/ /	
CHILD:		☐M ☐F	/ /	

COVERAGE EFFECTIVE DATE

PLAN CODE #	GROUP CODE #	PREMIUM AMOUNT	AMOUNT PAID	AGENT CODE
		$	$	

I wish to enroll in the Prepaid Plan. I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided in the description of benefits and surcharges. I have received and understand the outline of coverage.

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

Agent's Signature: _____

☐ CHOICE TWO - INDEMNITY

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.

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

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	DATE HIRED FULL TIME

NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION	OCCUPATION (TITLE)	EMAIL ADDRESS
Gulf Coast Regional Blood Center		

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

FIRST M.I. LAST	S.S.N. #	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 wish to enroll in the Choice Two dental plan. I have received and understand the outline of coverage.

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. 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.

AUTHORIZATION FOR DEDUCTION – Signature Required – Employer

Name _____ Social Security No. _____ I authorize _____

(Employer, Financial, or other organization)

To make ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly (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.**

Applicant's Signature :_____ Date Signed: _____