

DIVISION OF STATE GROUP INSURANCE

DENTAL INSURANCE

ENROLLMENT FORM



Select Your Type of Enrollment: **New Hire** **Qualifying Status Change** **Open Enrollment**
* NOTE: If checked, Agency Personnel Office must complete QSC Section in Part 4.

PLEASE PRINT

Social Security Number: _____ - _____ - _____ Name: _____

Address/City/State/Zip: _____

Work Phone: (____) _____ SUNCOM: _____ Home Phone: (____) _____

Date of Birth: ____/____/____ Sex: _____

PART 1: SELECT ONLY ONE DENTAL PLAN AND COVERAGE LEVEL
 (Premiums listed are monthly, divide by 2 for biweekly amounts.)

Dental Plan	Company Code	Product Code	Option Code	Coverage Level		
				Employee Only (01)	Employee + Family (20)	
ORAL HEALTH SERVICES DENTAL				In the box, place an E for ENROLLING or an S for STOPPING		
Pre-Paid	040	106	400	<input type="checkbox"/> \$10.98	<input type="checkbox"/> \$28.94	
DPPO	040	106	401	<input type="checkbox"/> \$28.50	<input type="checkbox"/> \$64.92	
AMERICAN DENTAL PLAN				Employee Only (01)	Employee + One Dependent (02)	Employee + Two or More Dependents (03)
Pre-Paid	030	103	300	<input type="checkbox"/> \$11.20	<input type="checkbox"/> \$19.06	<input type="checkbox"/> \$26.10
Indemnity	030	103	301	<input type="checkbox"/> \$14.30	<input type="checkbox"/> \$21.44	<input type="checkbox"/> \$28.60
CIGNA DENTAL PRE-PAID PLAN	025	103	250	<input type="checkbox"/> \$19.96	<input type="checkbox"/> \$37.62	<input type="checkbox"/> \$49.72
DENTICARE PLAN				Employee Only (01)	Employee + One Dependent (02)	Employee + Two or More Dependents (20)
Pre-Paid	020	103	200	<input type="checkbox"/> \$11.56	<input type="checkbox"/> \$20.40	<input type="checkbox"/> \$27.96
Indemnity (Insured)	020	103	202	<input type="checkbox"/> \$29.92	<input type="checkbox"/> \$59.94	<input type="checkbox"/> \$89.40

PART 2: ADD/DROP DEPENDENTS & SELECT DENTAL OFFICE

You may: **ADD** eligible dependents not currently covered & attach the required documentation and/or **DROP** ineligible dependents. (Attach an additional page if necessary.)

Add	Drop	Name (Last, First, MI)	<i>Please Print</i>	Sex	Social Security Number	Date of Birth	Relationship	Dental Office #
					- -	/ /	EMPLOYEE	
					- -	/ /		
					- -	/ /		
					- -	/ /		
					- -	/ /		
					- -	/ /		

PART 3: EMPLOYEE CERTIFICATION

I have read the information on the back of this form and I authorize my employer to reduce my salary in accordance with the benefits I have selected. **I understand my enrollment and/or changes will be effective the first of the month following a full payroll deduction, and that my elections are IRREVOCABLE until the next open enrollment, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within 31 calendar days of the Qualifying Status Change.**

Employee Signature: _____ Date: _____

PART 4: AGENCY CERTIFICATION

Hire Date: ____/____/____ Pay Plan: _____ SAMAS Org Code: _____

Coverage Effective Date: ____/____/____ Employment Status: _____

Agency Signature: _____ Date: ____/____/____

Check if the employee is an 8, 9 or 10 month faculty member.

Work Phone: (____) _____ SUNCOM: _____

DentalEnroll 08-02 (Make a copy for your records.) * QSC Code: _____ * QSC Date: ____/____/____

COMPLETION OF THIS FORM MEANS THAT YOU HAVE READ AND AGREE TO COMPLY WITH THE FOLLOWING:

- If you **add dependents** you must submit supporting documentation for dependent changes to your Agency Personnel Office. **If you have individual coverage and wish to add dependents, you must change to family coverage.**
- **Drop any ineligible dependents.** Examples of ineligible dependents are: overage dependents no longer attending college, dependents who become married, etc. **If you are dropping all of your dependents, please change your coverage to individual.**
- Dental Insurance premiums are automatically deducted on a pretax basis and choices made during the enrollment period will remain in effect for the Plan Year (January 1 - December 31).
- **I understand my enrollment and/or changes will be effective the first of the month following a full payroll deduction, and that my elections are IRREVOCABLE until the next open enrollment period, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within 31 calendar days of the Qualifying Status Change.**
- I authorize any participating dental office to release dental records and billing information concerning me or my dependents to my dental carrier for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize my dental carrier to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.
- I understand that I must select a network office if I enroll in a prepaid dental plan. If I enroll in an area with no network, I will not be able to access benefits during the plan year unless I travel to a network area.

Please give your completed and signed enrollment form to your Agency Personnel Office.

AGENCY PERSONNEL OFFICE:

PLEASE MAIL ORIGINAL PAGE OF THE ENROLLMENT FORM TO THE APPLICABLE COMPANY ADDRESS SHOWN BELOW.

AMERICAN DENTAL PLAN
P. O. BOX 769649
ROSWELL, GEORGIA 30076-8225

CIGNA DENTAL
P. O. BOX 189060
PLANTATION, FLORIDA 33324

DENTICARE/FORTIS BENEFITS
P.O. BOX 2606
BIRMINGHAM, ALABAMA 35202
ATTN: STATE OF FLORIDA
REPRESENTATIVE

ORAL HEALTH SERVICES
P.O. BOX 769649
ROSWELL, GEORGIA 30076-8225
ATTN: STATE OF FLORIDA
ENROLLMENT PROCESSING