luminare health℠

DENTAL ENROLLMENT FORM
Group Name: AS0112

Subscriber Name	Subscriber SSN	Date of Birth	Gender

Address	City	State	Zip Code

Occupation	Date Employed As Benefits Eligible	Hours Scheduled Per Pay

Reason for Enrollment (Must provide proof of dependent status for all enrollments)

☐ Open Enrollment ☐ Initial Enrollment

☐ Enrollment change due to (please check appropriate box below and provide verification as indicated):

- ☐ Marriage (certificate)
- ☐ Divorce (court order)
- ☐ Court ordered coverage (court order)
- ☐ Other:
- ☐ Birth of a child (birth certificate)
- ☐ No longer meets eligibility requirements
- ☐ Adoption or placement for adoption (court order)
- ☐ Loss of other health coverage (attach proof of loss of coverage)

Benefit Options and Coverage Selection	
Dental	☐ Decline ☐ Employee Only ☐ Employee + One ☐ Family

☐ Decline ALL Coverage - I wish to decline medical, dental and vision coverage.

Add Dependents- SPOUSE					
Last Name		First Name	M/I	Gender M/F	
SSN (required)	DOB	Relationship	FT Student Over 18 Y/N	Foster/Step Child Y/N	Disabled Y/N

Does this Spouse have access to other dental coverage through his or her employer? Please circle one:

Is this dependent covered under another dental plan?

(Circle one) Yes / No If yes, Name of Carrier:

Add Dependents					
Last Name		First Name	M/I	Gender M/F	
SSN (required)	DOB	Relationship	FT Student Over 18 Y/N	Foster/Step Child Y/N	Disabled Y/N

Does this dependent have access to other dental coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another dental plan? (Circle Yes / No If yes, Name of Carrier:

Add Dependents					
Last Name		First Name		M/I	Gender M/F

SSN (required)	DOB	Relationship	FT Student Over 18 Y/N	Foster/Step Child Y/N	Disabled Y/N

Does this dependent have access to other dental coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another dental plan? (Circle Yes / No If yes, Name of Carrier:

Add Dependents					
Last Name		First Name		M/I	Gender M/F

SSN (required)	DOB	Relationship	FT Student Over 18 Y/N	Foster/Step Child Y/N	Disabled Y/N

Does this dependent have access to other dental coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another dental plan? (Circle Yes / No If yes, Name of Carrier:

Employee Signature (Read and Sign Below)

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- I have read and understand my rights and Special Enrollment which are included with this enrollment form.
- My dependents, including step and foster children and those over the maximum age, are eligible for coverage based on plan provisions.
- If I decline the benefit options offered or do not complete and return this enrollment form I and/or my dependents may not enroll until the next Open Enrollment Period unless I experience a qualified change in family status. Changes in election due to a qualifying change in the family status must be made no later than 31 days after the date of the qualifying change in the status.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud by submitting an application, enrollment form, or filing a claim containing a false or deceptive statement may be guilty of fraud.

I declare that the information I have completed on this enrollment form is complete and true.

Signature: Date: