

| | | |
|------------------------|----------------------|-----------------------|
| OFFICE USE ONLY | Plan: _____ | Account Number: _____ |
| | Member Number: _____ | Code: _____ |

- If you wish to refuse coverage for yourself or a dependent, please complete the waiver at the bottom of the page -

EMPLOYER SECTION

| | | |
|--|---|---------------------------------------|
| Please check one box only: <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Open Enrollment | Effective Date: _____ mm / dd / yyyy | Name of Company: _____ (Division No.) |
| | Account Number: _____ | |

EMPLOYEE SECTION (Please print all information. Sign and date this form below.)

| |
|--|
| Employee Name: _____ (last) _____ (first) _____ (middle initial) |
| Home Address: _____ (street) _____ (city) _____ (state) _____ (zip) |
| Home Phone: _____ Work Phone: _____ FAX: _____ |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Eligible Children: _____ |
| Date of Hire: ____/____/____ Occupation: _____ Total hours worked per week: <input type="checkbox"/> Less than 30 <input type="checkbox"/> More than 30 |

BENEFIT COVERAGE OPTIONS:

| | |
|--|---|
| <input type="checkbox"/> Group PPO Dental (Underwritten by Security Life Insurance Company) <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Dental Health Services DHMO (prepaid) Plan <input type="checkbox"/> Gold Plan <input type="checkbox"/> Silver Plan <input type="checkbox"/> Bronze Plan * Dental office number (DHMO Only) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Vision Selection <input type="checkbox"/> Vision <input type="checkbox"/> Buy Up (B) * Vision office number: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * If dental or vision office is not selected, or is no longer available, you will be assigned an office by the plan |
|--|---|

ENROLLMENT INFORMATION: (Please provide all information for your self and each dependent to be enrolled)

| LAST NAME | FIRST NAME | SEX | BIRTH DATE (mm/dd/yyyy) | FULL-TIME STUDENT * | SOCIAL SECURITY | DENTIST # (2 per family) | VISION # (1 per family) | CHANGE STATUS OF DEPENDENT |
|-----------|------------|-----|-------------------------|---------------------|-----------------|--------------------------|-------------------------|--|
| self | | M F | / / | N/A | | | | <input type="checkbox"/> Add <input type="checkbox"/> Remove |
| spouse | | M F | / / | N/A | N/A | | N/A | <input type="checkbox"/> Add <input type="checkbox"/> Remove |
| child | | M F | / / | Y N | N/A | | N/A | <input type="checkbox"/> Add <input type="checkbox"/> Remove |
| child | | M F | / / | Y N | N/A | | N/A | <input type="checkbox"/> Add <input type="checkbox"/> Remove |
| child | | M F | / / | Y N | N/A | | N/A | <input type="checkbox"/> Add <input type="checkbox"/> Remove |

* For all dependents age 19 or older, please provide proof that he/she is a full-time student.

I hereby declare that I am a full-time employee of the employer indicated above and that I regularly work for my employer at least 30 hours per week. Additionally, I hereby request the group benefit plans for which I am or may become eligible under the policies or contracts issued by the Insurer or Benefit Provider. I authorize the deductions from my earnings of any contributions I may have to make toward the cost and understand that my request for group benefits shall include this form or any other form which may be required. All information given by me on this form is true and complete and is offered as a request to grant benefit coverages.

Employee Signature X _____ Date _____

Dental HMO benefits provided by Dental Health Services. DHMO Vision provided by Vision Plan of America. PPO Dental and Indemnity Ortho insured by Security Life Insurance Company of America.

WAIVER OF COVERAGE
Complete this section only if you are refusing dental coverage for yourself or a dependent. Then sign, date and return this form to your employer.

Refusing coverage for: Self Spouse Child(ren)

Reason for refusal: Covered under spouse's Group Insurance Plan. Name of Plan: _____
 Other/Explain: _____

I understand that if I later wish to enroll or re-enroll, I must provide satisfactory evidence of insurability to the Insurance Company or be subject to limited benefits for a specified period of time. I also understand that I may not be eligible for all plans made available through my employer.

Employee Name (Print): _____ Company Name: _____
 Employee Signature: X _____ Date: _____