Inshore Benefits

Employee Application — Dental & Vision

Employer Name:	Division #:

1. EMPLOYEE INFORMATION		Requested Effective Date:
Employee First Name:	Employee Last Name:	
Social Security #:	Date of Hire:	
Mailing Address:		
City:	State:	Zip Code:
Primary Phone:	Email:	

Your email address will not be used for any purpose other than communications from Inshore Benefits Trust.

2. REASON FOR COVERAGE	☐ **New Coverage** (give reason below)	**Date of Qualifying Event:**

☐ New Group Enrollment ☐ Open Enrollment (vision only) ☐ New Hire ☐ Rehire within 30 days - Reinstate to term date

☐ Rehire more than 30 days - subject to waiting periods ☐ Part-time to Full-time ☐ Other:

New Group Enrollment: Eligible employees and their dependents must enroll at initial new group enrollment to be eligible for coverage. Members who waive coverage must have a qualifying event or wait until open enrollment at a later date. FL residents are not eligible for coverage.

New Hire or Member with Qualifying Event: We must receive the completed application within 30 days of the date of hire or of the qualifying event.

Late Enrollee: A late enrollee is an employee and/or their dependent(s) who has submitted their Enrollment Application more than 30 days after their eligibility date. These employee's and/or dependent(s) must have a qualifying event to enroll at a later date and provide proof of the qualifying event. Otherwise, the employee will not be eligible for coverage until the group's open enrollment period.

Dependent(s): An eligible dependent(s) declining coverage cannot enroll at a later date unless the dependent(s) can show proof of loss of prior coverage. An eligible dependent(s) is an individual's spouse/domestic partner, and any child of the enrolled applicant or spouse/domestic partner, who is under age 26. Dependent children may remain on this plan to age 26. If an enrolled member would like to enroll their dependent(s), the dependent(s) must have a qualifying event or wait until open enrollment. Dependent child orthodontia age limits vary based on carrier.

3. PLAN SELECTION (Options available are based upon your employer's offering).

Voluntary Ameritas Dental	Voluntary Delta Dental	Voluntary Humana Dental	Voluntary Vision Service Plan	Employer Sponsored Vision Service Plan
☐ Ameritas Dental	☐ Delta PPO ☐ Delta Care DHMO*	☐ PPO 14 Unlimited ☐ PPO 14 Traditional Preferred 1500 ☐ PPO 14 Preventive Plus 1000 ☐ DHMO LS200*	☐ Vision*	☐ Vision
Locate provider at: www.ameritas.com	*DHMO Primary Dentist: _____ Locate provider at: www.deltadentalins.com	*DHMO Primary Dentist: _____ Locate provider at: www.humana.com	*List VSP Plan Name _____ Locate provider at: www.vsp.com	Locate provider at: www.vsp.com
☐ Employee ONLY ☐ Employee + 1 ☐ Employee + 2 or more	☐ Employee ONLY ☐ Employee + 1 ☐ Employee + 2 or more	☐ Employee ONLY ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	☐ Employee ONLY ☐ Employee + 1 ***or*** Employee + Child(ren) ☐ Family	☐ Employee ONLY ☐ Employee + 1 ***or*** Employee + Child(ren) ☐ Family

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4. EMPLOYEE ENROLLMENT INFORMATION

Dental	Vision	First Name	MI	Last Name	Gender	Relationship	DOB MM/DD/YYYY
☐	☐				☐ M ☐ F	☐ Self	
☐	☐				☐ M ☐ F	☐ Spouse ☐ DP	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	

*Check this box only if enrolling a disable dependent child age 26 or over and if disability occured prior to limit age.

5. HOW TO WAIVE YOUR DENTAL WAITING PERIODS

Dental plans have a 12 month major service waiting period for services. This may be waived if proof of 12 months of continuous prior coverage is included with this application. Please provide a copy of your dental ID card with this application.

Who is your current dental carrier? ☐ Proof of prior coverageattached	**Dates of coverage from:** **to:**

I certify on behalf of my eligible family dependents and myself that the answers contained in this application are complete and accurate to the best of my knowledge. I am at least 18 years of age. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

Employee Signature: (X)	**Date:**