Inshore Benefits

Change Request Form — 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. CHANGE OR QUALIFYING EVENT (provide reason below)			Date of change or qualifying event:	
☐ Marriage ☐ Domestic Partnership	☐ Birth ☐ Adoption	☐ Divorce ☐ Address Change	☐ Loss of other group coverage. Proof of loss required.	☐ Other:
All applications for qualifying events must be submitted to **Pathian** within 60 days of the qualifying event. The effective date will be the 1st of the month following receipt of application, waiting period, or qualifying event.				

3. COVERAGE SELECTION				
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

4. WAIVING 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 coverage attached.
Dates of coverage from:	Dates of coverage to:

Inshore Benefits

Change Request Form — Dental & Vision

Employer Name:	Division #:

5. 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	
☐	☐				☐ M ☐ F	☐ Child	
☐	☐				☐ M ☐ F	☐ Child	
☐	☐				☐ M ☐ F	☐ Child	

Eligibility Note: Eligible employees, and their dependents, must enroll within 30 days of the group's new hire waiting period or a qualifying event.

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. 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.

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