

Inshore Benefits

Employee Application — Dental & Vision



Employer Name:	Division #:
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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	<input type="checkbox"/> New Coverage (give reason below)	Date of Qualifying Event:
<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Open Enrollment (vision only) <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire within 30 days - Reinstatement to term date <input type="checkbox"/> Rehire more than 30 days - subject to waiting periods <input type="checkbox"/> Part-time to Full-time <input type="checkbox"/> Other:		
<p>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.</p> <p>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.</p> <p>Late Enrollee: A late enrollee is an employee and/or their dependent(s) who has submitted their Enrollment Application <u>more than 30 days</u> after their eligibility date. These employee's and/or dependent(s) must have a qualifying event to enroll at a later date <u>and</u> provide proof of the qualifying event. Otherwise, the employee will not be eligible for coverage until the group's open enrollment period.</p> <p>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.</p>		

3. PLAN SELECTION (Options available are based upon your employer's offering).			
Delta Dental	Vision Service Plan	Voluntary Humana Dental	Voluntary Ameritas Dental
<input type="checkbox"/> Voluntary <input type="checkbox"/> Delta PPO <input type="checkbox"/> Delta Care DHMO* <input type="checkbox"/> Employer Sponsored	<input type="checkbox"/> Voluntary* <input type="checkbox"/> Employer Sponsored	<input type="checkbox"/> PPO 14 Unlimited <input type="checkbox"/> PPO 14 Traditional Preferred 1500 <input type="checkbox"/> PPO 14 Preventive Plus 1000 <input type="checkbox"/> DHMO LS200*	<input type="checkbox"/> Voluntary
*DHMO Primary Dentist: <hr/> Locate provider at: www.deltadentalins.com	*List Voluntary Plan Name <hr/> Locate provider at: www.vsp.com	*DHMO Primary Dentist: <hr/> Locate provider at: www.humana.com	Locate provider at: www.ameritas.com
<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2 or more	<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee +1 or +Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2 or more

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Employee Name:	

4. EMPLOYEE ENROLLMENT INFORMATION

Dental	Vision	First Name	MI	Last Name	Gender	Relationship	DOB MM/DD/YYYY
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Self	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> DP	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Disabled*	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Disabled*	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Disabled*	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Disabled*	

*Check this box only if enrolling a disable dependent child age 26 or over and if disability occurred 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?	<input type="checkbox"/> Proof of prior coverage attached	Dates of coverage from: _____ to: _____
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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:
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