Group Enrollment/Change Request

ASSURANT Employee Benefits

Carrier Name		
Group Name	**Group Number**	**Location/Division**

A. Type of Activity – To be completed by Employer. (Please print clearly.)

Check one:

1. Enrollment ☐ New [Enrollee/Member] Effective Date ___/___/___ Date of Hire ___/___/___

2. Change – Check all that apply	**Date of Event**	**Reason**
☐ Add Spouse/Civil Union Partner/Domestic Partner	___/___/___	_____
☐ Add Dependent Children	___/___/___	_____
☐ Name Change	___/___/___	_____
☐ Change Plan	___/___/___	_____
☐ Add/Change Office ID Numbers: Dentist	___/___/___	_____

(Make changes in Section C which apply to prepaid plans.)

3. Remove or Terminate – Check all that apply	**Effective Date**	**Reason**
☐ Remove Spouse/Civil Union Partner/Domestic Partner *	___/___/___	_____
☐ Remove Dependent Child*	___/___/___	_____
☐ Employee Withdrawal/Termination	___/___/___	_____

NOTE: Employee must be enrolled for spouse/dependent child(ren) to have coverage. This allows for continued coverage after employment coverage ends. (COBRA – Federal; NJSGC – State)
*Please complete Name and Add/Remove/Other/Continue columns in Section D.

4. Coverage Continuation with COBRA/NJSGC	**Length of Continuation (in months):**	**Date of Loss of Coverage:**	**Qualifying Event #:**	**Date of Qualifying Event:**	**Billing:** Group	Home (What address?)
☐ Employee	☐ 18 ☐ 29	___/___/___	_____	___/___/___	☐	☐ (section B)
☐ Spouse/Civil Union Partner/Domestic Partner	☐ 18 ☐ 36	___/___/___	_____	___/___/___	☐	☐ (section B) or ☐ (section E)
☐ Dependent Child	☐ 18 ☐ 36	___/___/___	_____	___/___/___	☐	☐ (section B) or ☐ (section F)

B. Employee Information – To be completed by Employee (Please print clearly.)

EMPLOYEE FIRST NAME	MI	LAST NAME	
ADDRESS	APT	CITY, STATE	ZIP CODE
SOCIAL SECURITY NUMBER	BIRTHDATE	HOME PHONE	GENDER: ☐ Male ☐ Female
EMPLOYER NAME		WORK PHONE	HOURS WORKED PER WEEK:
WORK ADDRESS	CITY, STATE	ZIP CODE	DATE OF EMPLOYMENT

Other Dental Coverage: ☐ Yes ☐ No *If, "Yes:"* **Insurer Name** _____ **Policy #** _____

Other Vision Coverage: ☐ Yes ☐ No *If, "Yes:"* **Insurer Name** _____ **Policy #** _____

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C. Plan Option – To be completed by Employee. (Please print clearly.)

This section only applies to prepaid plans. *(Add/Change Office ID numbers or dentist.)*

Activity: ☐ Add ☐ Remove ☐ Continuation ☐ Other change *If a name change, indicate prior name:* *Current patient?*

Dentist Name _____ Facility ID # *(required)* _____ ☐ Yes ☐ No

Address _____ ZIP Code _____

D. Other Individuals Covered – To be completed by Employee. (Please print clearly.)
Identify individuals other than yourself for whom you are adding/removing/continuing coverage. Attach additional pages if necessary, with your signature and date. Attach proof if full-time post-secondary student.

Do you have eligible dependents? ☐ Yes ☐ No If "Yes," complete below to enroll them.

Spouse; Domestic or Civil Union Partner Name	(A)dd, (R)emove, (C)ontinue: Spouse Civil UnionPartner (NJSGC) Domestic Partner (NJSGC)	Social Security Number	Gender (M) (F)	Birthdate mm/dd/yy	Dentist Name & ID # *(required)*	Current Patient? (Y) (N)	Employed? (Y) (N) (If yes, complete section E.)

Dependent Child(ren) Name(s)	(A)dd, (R)emove, (C)ontinue: Son Daughter Other	Social Security Number	Gender (M) (F)	Birthdate mm/dd/yy	Dentist Name & ID # *(required)*	Current Patient? (Y) (N)	Living with employee? (Y) (N) (If no, complete section F.)

If the last name of the dependent(s) is different from the employee's, please explain:

E. Additional Spouse/Civil Union/Domestic Partner Information – To be completed by Employee. (Please print clearly.)
If not applicable, please mark as "NA."

EMPLOYER NAME

EMPLOYER ADDRESS CITY, STATE ZIP CODE EMPLOYER PHONE

Home or billing address same as employee? ☐ Yes ☐ No *If "No," complete below.*

ADDRESS APT CITY, STATE ZIP CODE

Group Name	Group Number	Location/Division

F. Additional Dependent Child(ren) Information – To be completed by Employee. (Please print clearly.)
Provide information below about children listed in Section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s) _____	Name(s) _____
Street/apt _____	Street/apt _____
City, State, ZIP _____	City, State, ZIP _____
Reason for difference _____	Reason for difference _____

G. Employee Signature – I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Employee Signature (Required) _____ Date ___/___/___

E-mail Address _____

H. Conditions of Enrollment – Applicant Acknowledgements and Agreements
On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Union Security DentalCare of New Jersey, Inc. or Union Security Insurance Company, or any consumer reporting agency acting on behalf of Union Security DentalCare of New Jersey, Inc. or Union Security Insurance Company, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Union Security DentalCare of New Jersey, Inc. or Union Security Insurance Company has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Union Security DentalCare of New Jersey, Inc. or Union Security Insurance Company will provide coverage in accordance with the terms of the contract for the group plan or policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan or policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

I. Employer Verification – To be completed by Employer.

Employer Signature (Required) _____ Date ___/___/___

Title _____

Coverage must be verified with the appropriate company (Union Security DentalCare of New Jersey, Inc. or Union Security Insurance Company), based on the Plan Option selected in section C.

Instructions

Employers – You must complete the Employer Group Information and sections A and I in order for this application to be processed.

Employees – You must complete sections B through G in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent experiences a qualifying event and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC election. Instead, select "Other" in Section A3, and attach proof of the event.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.
- You can obtain the dentists correct names and addresses from the appropriate directory of dentists. You may also obtain each dentist's facility ID number from the directory or by contacting the provider directly.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours

C2. Employee enrollment in Medicare (COBRA only)

C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)

C4. Death of employee

C5. Loss of dependent child status under the plan