

## DENTAL INSURANCE ENROLLMENT APPLICATION

*Entire form must be completed. Coverage is subject to approval.*

☒ **Add Adult Child who will be at least age 19 but not yet age 26 as of October 1, 2010**

Note: Your current taxation election – to pay the premium on either a before- tax or after- tax basis – will remain in effect. However, if your premium cost is changing because you are adding the “children” coverage tier for the first time, you can elect to change taxation of the premium. Contact Human Resources at 870-575-8400 if this is the case and we will provide you with the required form.

### PART A: EMPLOYEE/SUBSCRIBER INFORMATION:

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ INITIAL \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year

HOME ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SOC SEC NUMBER \_\_\_\_\_

MARITAL STATUS: ☐ Single ☐ Married GENDER: ☐ Male ☐ Female

DOES YOUR CHILD CURRENTLY HAVE OTHER DENTAL COVERAGE \_\_\_\_\_ IF YES, COMPLETE THE FOLLOWING:  
(Y/N)

POLICYHOLDER'S NAME \_\_\_\_\_ NAME OF EMPLOYER \_\_\_\_\_

POLICY# \_\_\_\_\_ NAME OF CARRIER \_\_\_\_\_

### PART B: DEPENDENT INFORMATION: *List the eligible adult children (born 10-2-1985 to 10-1-1991) you wish to add*

	Last Name	First Name	MI	Social Security Number	Date of Birth (Mo/Day/Year)	Sex (M/F)	Other Coverage? (Y/N)
Child							
Child							
Child							

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Send original to UAPB Human Resources by 9-30-2010.**  
**If faxing, send to 870-575-4658. Keep fax confirmation as your proof.**

### PART C: TO BE COMPLETED BY THE EMPLOYER:

Effective Date: 10-1-2010 Group #: 9304 - 1500  
Campus: UAPB