dental health OPTIONS™
by Health Resources, Inc.

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ENROLLMENT APPLICATION – MEMBER

ALL INFORMATION IS REQUIRED IN ORDER TO COMPLETE ENROLLMENT OR MAKE CHANGES

Monthly rates per tier: Tier 1: $24.16 – Tier 2: $50.72 – Tier 3: $55.80 – Tier 4: $85.16

Member(**EMPLOYEE**) Social Security Number:	Site Location:	Group Legal Name : **Hancock Board of Education**

DHO Plan:		**QUALFYING EVENT:**	Employee Hire Date:
☐**ELECT:** Employee ☐**ELECT:** Employee and Spouse ☐**ELECT:** Employee and Child(ren) ☐**ELECT:** Family	☐**ADD** New Enrollment ☐**CANCEL** Coverage ☐**CHANGE** to Coverage Qualifying Event Date: **MM/DD/YYYY**	☐Birth/Adoption ☐Coverage-Gained ☐ Coverage-Loss ☐Death ☐Divorced or Legal Separation ☐Married ☐New Employee ☐Open Enrollment ☐Over Age Limit ☐Personal Information Update ☐Term-Involuntary ☐Term-Voluntary	**MM/DD/YYYY** ☐Hourly ☐Salary

☐Add ☐Cancel ☐Change ☐**DECLINE:** I decline coverage for myself and dependent(s)	**EMPLOYEE** Last Name	First Name	MI	Gender M / F	Birth Date	Relationship to Member SELF
	Mailing Address	City			State	Zip
	Email	Home Telephone			☐Single ☐Married ☐Divorced or Legal Sep.	

☐Add ☐Cancel ☐Change	**SPOUSE** Last Name	First Name	MI	Gender M / F	Birth Date	Relationship to Member SPOUSE
	Social Security Number	Other Dental Coverage				

☐Add ☐Cancel ☐Change	**DEPENDENT** Last Name	First Name	MI	Gender M / F	Birth Date	Relationship to Member DEPENDENT
	Social Security Number	Other Dental Coverage and Guardian Birth Date				☐Physical Disability ☐Full Time Student ☐Court Order

☐Add ☐Cancel ☐Change	**DEPENDENT** Last Name	First Name	MI	Gender M / F	Birth Date	Relationship to Member DEPENDENT
	Social Security Number	Other Dental Coverage and Guardian Birth Date				☐Physical Disability ☐Full Time Student ☐Court Order

☐Add ☐Cancel ☐Change	**DEPENDENT** Last Name	First Name	MI	Gender M / F	Birth Date	Relationship to Member DEPENDENT
	Social Security Number	Other Dental Coverage and Guardian Birth Date				☐Physical Disability ☐Full Time Student ☐Court Order

REQUIRED DOCUMENTATION: if you have checked any of the above boxes that apply:

Physical Disability:	**Full Time Student:**	**Marriage/Divorce/Legal Sep./Court Order:**	**Guardianship Papers:**
Requires statement from physician for coverage dependents only.	An over-age dependent, if full-time student, school schedule may be required. Contact employer's benefits administrator for submission procedure.	Requires marriage certificate, divorce decree, legal separation agreement, court order that states dependent responsibility.	Required for dependents other than biological children or step-children.

SIGNATURE, RELEASE AND ASSIGNMENT:

By submitting this application, subscriber understands that coverage may not change until next open enrollment period, including coverage on dependents unless there is a change in family status. If coverage is approved and issued, subscriber authorizes Health Resources, Inc. (HRI), to make payment of any benefits directly to the dentist as the supplier of services rendered. Subscriber understands that the dentist(s) chosen to use are independent contractors, and are not employees of HRI and authorizes the dentist to release to HRI any information regarding history, symptoms, treatment, examination results or diagnosis. Subscriber further authorizes HRI and the dentists providing services to transmit by any means any and all information regarding services performed for self and dependents enrolled under this plan as may be required for the payment or evaluation of claims. A photo copy of this authorization shall be considered as effective and valid as the original. Subscriber understands they have the right to receive a copy of this authorization.

If this application is accepted, the information herein is an integral part of the plan. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and will be reported.

Signature of Employee______________________________ Date__________

Signature of Employer Benefits Administrator/Authorized Agent______________________________ Date__________

BA SIGNATURE NOT REQUIRED IF MEMBER APPLICATION IS SUBMITTED WITH EMPLOYER APPLICATION