

# AIG Employee Choice Dental Employee Application



## OFFICE USE ONLY

Plan: \_\_\_\_\_  
Member Number: \_\_\_\_\_

Account Number: \_\_\_\_\_  
Code: \_\_\_\_\_

- If you wish to refuse coverage for yourself or a dependent, please complete the waiver at the bottom of the page -

## EMPLOYER SECTION

Please check one box only:  
 Initial Request  
 Change  
 Open Enrollment

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Name of Company: \_\_\_\_\_  
Account Number: \_\_\_\_\_

## EMPLOYEE SECTION (Please print all information. Sign and date this form below.)

Employee Name: \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle initial)

Home Address: \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

Marital Status:  Single  Married  Divorced  Domestic Partner  Eligible Children: \_\_\_\_\_

Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation: \_\_\_\_\_ Total hours worked per week:  Less than 30  More than 30

## BENEFIT COVERAGE OPTIONS: (- IMPORTANT - You can only elect those coverages offered by your employer)

<b>DUAL CHOICE (1)</b> <input type="checkbox"/> DHMO <input type="checkbox"/> PPO	<b>DUAL CHOICE (2)</b> <input type="checkbox"/> PPO HIGH <input type="checkbox"/> PPO LOW	<b>TRIPLE CHOICE</b> <input type="checkbox"/> DHMO <input type="checkbox"/> PPO HIGH <input type="checkbox"/> PPO LOW	<b>STAND ALONE</b> <input type="checkbox"/> EMPLOYER CHOICE
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## ENROLLMENT INFORMATION: (Please provide all information for your self and each dependent to be enrolled)

LAST NAME	FIRST NAME	SEX	BIRTH DATE (mm/dd/yyyy)	FULL-TIME STUDENT *	SOCIAL SECURITY	DENTIST #	VISION #	ORTHO #	CHANGE STATUS OF DEPENDENT
self		M F	/ /	N/A					<input type="checkbox"/> Add <input type="checkbox"/> Remove
spouse		M F	/ /	N/A					<input type="checkbox"/> Add <input type="checkbox"/> Remove
child		M F	/ /	Y N					<input type="checkbox"/> Add <input type="checkbox"/> Remove
child		M F	/ /	Y N					<input type="checkbox"/> Add <input type="checkbox"/> Remove
child		M F	/ /	Y N					<input type="checkbox"/> Add <input type="checkbox"/> Remove

\* For all dependents age 19 or older, please provide proof that he/she is a full-time student.

I hereby declare that I am a full-time employee of the employer indicated above and that I regularly work for my employer at least 30 hours per week. Additionally, I hereby request the group benefit plans for which I am or may become eligible under the policies or contracts issued by the Insurer or Benefit Provider. I authorize the deductions from my earnings of any contributions I may have to make toward the cost and understand that my request for group benefits shall include this form or any other form which may be required. All information given by me on this form is true and complete and is offered as a request to grant benefit coverages.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**CompBenefits DHMO underwritten by:** CompBenefits Insurance Company; CompBenefits Company (Florida only); American Dental Plan of North Carolina, Inc. (North Carolina only); DentiCare, Inc. (d/b/a CompBenefits) (Texas only); CompBenefits Dental, Inc. (Illinois, Kentucky, Missouri & West Virginia only); American Dental Providers of Arkansas, Inc. (Arkansas only); CompBenefits of Alabama (Alabama only); CompBenefits of Georgia (Georgia only)

**Healthplex DHMO underwritten by:** Dentcare Delivery Systems, Inc. (in NY) and International Healthcare Services, Inc. (in NJ)

## WAIVER OF COVERAGE

Refusing coverage for:  Self  Spouse  Child(ren)

Reason for refusal:  Covered under spouse's Group Insurance Plan. Name of Plan: \_\_\_\_\_  
 Other/Explain: \_\_\_\_\_

I understand that if I later wish to enroll or re-enroll, I must provide satisfactory evidence of insurability to the Insurance Company or be subject to limited benefits for a specified period of time. I also understand that I may not be eligible for all plans made available through my employer.

Employee Name (Print): \_\_\_\_\_ Company Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_