WD Associates
Dental Enrollment Form

DIRECTIONS TO EMPLOYEE:
Complete all requested information. Print clearly using blue or black ink. Sign where indicated and return completed form to your Human Resources Representative

The Loomis Company Use Only	
Remarks:	
Effective Date Employee:	
Effective Date Dependent::	
Processed Date:	User I.D.

Employee Information

Employee Name (Last First Middle Initial)	Social Security Number	Sex ☐ M ☐ F	Employee's Date of Birth (MM/DD/YY) / /	Spouse's Date of Birth (MM/DD/YY) / /

Street Address	Home Phone Number ( )	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed	Apply for Dental ☐ Single ☐ Family ☐ Decline
City / State	Zip Code		

Below indicate your beneficiaries for Life, AD&D (Attach separate list if choosing more than two))
NOTE: Combined percentage for all beneficiaries must not exceed 100%

Volume of Life Insurance: N/A

Name:	Address:	Date of Birth:	Relationship:	Percent:
Name:	Address:	Date of Birth :	Relationship:	Percent:

Use this space to list all eligible dependents. Last name required if different from employee.

Spouse's Name(Last First MI)	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number	Check if Handicapped	
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Step Child ☐ Other	☐	Full time College Student ☐ N ☐ Y If yes, Univ. Name ____ # Of Credits ____ Est. Grad. Date ____
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Step Child ☐ Other	☐	Full time College Student ☐ N ☐ Y If yes, Univ. Name ____ # Of Credits ____ Est. Grad. Date ____
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Step Child ☐ Other	☐	Full time College Student ☐ N ☐ Y If yes, Univ. Name ____ # Of Credits ____ Est. Grad. Date ____

Note: You must answer either "Yes" or "No to the following question. Failure to do so may result in the delay of claims processing.
Are you or any of your covered dependents covered by other insurance? ☐ NO ☐ YES If yes, complete the information in the "Other Insurance" section.

Name of other Insurance Company	Group No.	FOR EMPLOYER USE ONLY:			
		Medical Coverage Effective Date:	Dental Coverage Effective Date:		Employment Status ☐ Full Time ☐ Part-Time ☐ Retiree
Address of other Insurance Company		Account Number:	Location:	Hire Date	
		CERTFICATE OF CREDITABLE COVERAGE ATTACHED ☐ Yes ☐ No	☐ Hourly ☐ Salary		
Employee Signature	Date	Signature of Employer			Date

You have the option to reject the insurance coverage offered by your employer for yourself, your dependent(s)/spouse or both. If you wish to reject coverage, complete the section below.

☐ **YES** – I am rejecting Employee Coverage ☐ **YES** – I am rejecting Dependent/Spouse Coverage Only.

I hereby certify that I have been given the opportunity to apply for all insurance coverage for which I may be eligible under the Group Policy issued by my Employer. I am NOT applying for all coverage for which I am eligible. I understand the benefits available under this plan, but **I Decline** all, or dependent, health coverage because I and/or my dependents are covered by:

☐ Another benefit plan offered by my employer.
☐ An individual plan.
☐ A Government plan (Type) ___________________________.
☐ I and/or my dependents are currently not covered by any other Group Health Benefit Plan.
☐ COBRA or State Continuation.
☐ My spouse's group coverage.
☐ Other (Explain) _____

Names of dependents rejecting coverage for this group plan:____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this employer health benefit plan at a later time, the application may be subject to an extended waiting period for preexisting conditions or I may be delayed until the employer's open enrollment period.

Signature of Employee ______________________________ Date ______________________

AUTHORIZATION

I AUTHORIZE any physical, medical practitioner, hospital, clinic, other medical related facility, or reinsuring company, employer, or third party administrator having information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the group policy holder, the plan sponsor, The Loomis Company – Benefits Division, or its legal representative any and all such information.

I understand that the information obtained by use of this Authorization will be used by The Loomis Company – Benefits Division to determine eligibility for benefits under an existing policy. Any information obtained will not be released by The Loomis Company – Benefits Division to any person or organization EXCEPT to the group policy holder, the plan sponsor or as may be otherwise lawfully required or as I may further authorize.

I acknowledge that I may request a copy of this Authorization. I furthermore acknowledge that a photographic copy of this authorization shall be as valid as the original.

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Dependent's Signature (over age 18 only) Date