

ASI GROUP DENTAL PLAN

Employee Enrollment / Change Form

Please write legibly, complete all applicable sections, and sign where indicated. If you are refusing coverage for yourself or your dependents, you must complete and sign the waiver on the reverse side of this form (check with your employer to see if waiving coverage is an option)

EMPLOYER INFORMATION				
Group Name _____				
<input type="checkbox"/> New Group Enrollment/Effective Date _____ <input type="checkbox"/> COBRA Enrollment/Qualifying Date _____				
<input type="checkbox"/> Family Addition/Effective Date _____				
<input type="checkbox"/> New Hire/Effective Date _____				
<input type="checkbox"/> Other-Specify: _____ Effective Date _____				
EMPLOYEE INFORMATION				
Last Name		First Name		Middle Initial
Home Address		City/State		Zip Code
Home Phone		Work Phone		Hire Date
Social Security Number		Date of Birth		Sex
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated				
Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Other Carrier's Name: _____				
SPOUSE				
Last Name		First Name	Sex	Date of Birth
CHILDREN				
Last Name		First Name	Sex	Date of Birth
1.				
2.				
3.				
4.				
5.				
AUTHORIZATION FOR DISCLOSURE OF DENTAL INFORMATION				
I provide this information as part of my employer's application for coverage for myself and my eligible dependents listed above. To the extent that I am responsible for the payment of dental plan costs, I authorize appropriate deductions from my earnings. I authorize any "provider of care", insurer, third party administrator, or dental plan to release dental information regarding me, my spouse and/or my children as necessary and for the purpose of determining claims for benefits, quality assurance, and peer review. This authorization will remain in effect for the term of coverage under my employer's dental plan. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to a copy of this authorization.				
Employee Signature: _____ Date: _____				

Mail completed form to Administrative Solutions Inc., P.O. Box 5809 Fresno CA 93755-5809 or fax to 559-256-1321