UNIVERSAL Group Dental and Vision Enroll/Change/Term/Waive Form

SECTION 1: Employee Information

Name (Last, First, MI):	Social Security #:	Date of Birth:
Address (#, Street, Apt or Unit #)	City, State	Zip Code

☐ Male ☐ Female	☐ Single ☐ Married	☐ Separated ☐ Divorced	☐ Domestic Partner ☐ Widowed	Phone #:

Job Title:	Date of Hire:	Hours per week:	Work Email:
Employer Name:	Work Location (City, State):	Pay: $_____	☐ Annually ☐ Hourly ☐ Weekly ☐ Bi-Weekly

SECTION 2: Enrollment Elections/Declinations:

Dental:	Enroll Single____	Employee + Spouse____	Employee + Child(ren)____	Family____	Term or Waive ____
Vision:	Enroll Single____	Employee + Spouse____	Employee + Child(ren)____	Family____	Term or Waive ____

SECTION 3: Complete if terming/waiving: I and/or my dependents are waiving dental due to coverage through:

Spouse___	2nd job___	Parent___	COBRA___	Military___	Medicare ___	Medicaid ___	Other ___	None ___

If Spouse or Parent, is coverage through an employer?	If "Other", explain:	
Dental Insurer:	Policyholder:	Policy #:
Vision Insurer:	Policyholder:	Policy #:

SECTION 4: Dependent Information

Relation:	Name (Last, First, MI):	M/F:	Social Security #:	Date of Birth:	Coverage(s) Elected:
Spouse ☐ Add ☐ Term					Dental ___ Vision ___
Child 1 ☐ Add ☐ Term					Dental ___ Vision ___
Child 2 ☐ Add ☐ Term					Dental ___ Vision ___
Child 3 ☐ Add ☐ Term					Dental ___ Vision ___
Child 4 ☐ Add ☐ Term					Dental ___ Vision ___

SECTION 5: Employee Signature

I certify that the information provided herein is complete and true. I understand that if any of the information was listed incorrectly, is missing or incomplete, that it is my responsibility to notify my employer immediately and in writing and that it is likely my coverage(s) will be impacted as a result and that any claims incurred may not be able to be processed until I do so. I further understand that my employer and/or the insurers may require legal documentation, such as a Social Security card, birth certificate, marriage certificate, etc. to process enrollment transactions and that I must provide whatever documentation is required if so. I agree that all of the information above represents my dental elections/declinations at this time and I understand that if at any time I need to make changes to these elections due to a qualifying life event, changes in my or my family's eligibility for benefits, personal information, disability status, Medicare eligibility, Medicaid eligibility or student status, that I will notify my employer within 20 days. I have received a copy of, have read thoroughly through and fully understand all of my employer's benefits information including plan documents, rates, notices and disclosures, the ERISA wrap document, SBCs, SPDs, plan flyers, General Rights Notice, and Model Health Insurance Exchange Notice. Please accept my signature on this form in place of the insurer form(s) to enroll in/waive benefits as indicated herein:

_____	_____	_____
Employee Signature	Printed Name	Date

SECTION 6: Employer Authorization

_____	_____	_____
Employer Signature	Printed Name, Title	Date

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