

# GROUP DENTAL EMPLOYEE ENROLLMENT FORM

**Administered by:**

Companion Life Insurance Company  
 800 Main Street, P.O. Box 1535  
 Dubuque, IA 52004-1535  
 Telephone Number: 877-676-5789  
 Fax: 563-557-3351

**Underwritten by:** Companion Life Insurance Company



P.O. Box 100102 | Columbia, SC 29202-3102  
 800-753-0404 (Phone) | 800-836-5433 (Fax)

Companion Life Insurance Company		Companion Life Use ONLY	
<input type="checkbox"/> New Employee	<input type="checkbox"/> Change Address	<input type="checkbox"/> COBRA	Approved: <input type="checkbox"/> Declined: <input type="checkbox"/>
<input type="checkbox"/> Add/Increase Coverage	<input type="checkbox"/> Change Dependent Coverage		Date: _____
	<input type="checkbox"/> Change Class or Status		By: _____
	<input type="checkbox"/> Terminate Coverage		

POLICYHOLDER INFORMATION – to be completed by the Policyholder or Group Administrator	
Employer Name: _____	DBA: _____
Group Number: _____	Dept/Div Number: _____ Class: _____

ENROLLEE INFORMATION (PLEASE PRINT)–to be completed by the Employee/Enrollee			
Last Name (Include Jr., Sr., etc.)	First Name	M.I.	
Street Address	Apt Number	City	State/Zip
Social Security Number	Primary Phone Number Work Phone Number		Email Address
Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth(MM-DD-YY) / /	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Occupation	Earnings\$ _____ Do not include overtime or bonuses
		Hours Worked Per Week _____	Hire Date: / /
			Coverage Effective Date: / /

PLAN AND COVERAGE SELECTION			
<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Children <input type="checkbox"/> Family			

DEPENDENT INFORMATION (please attach additional pages as needed)			Do any of your Dependents have any other dental coverage?
Spouse Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No

**DEPENDENTS:** Eligible Dependents are determined by your Employer's eligibility terms.

*If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Enrollee.*

**AUTHORIZATION FOR DEDUCTION**

I  agree  do not agree to have the certificate documents delivered to the Policyholder electronically.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages. I affirm, to the best of my knowledge and belief, that all information given by me on this form is true and complete. I have read or had read to me any Fraud notice below applicable to my state of issue of this enrollment form.

Enrollee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REFUSAL/WAIVER – Complete ONLY if you are declining coverage.**

I have been offered insurance coverage as permitted by my Employer and decline to participate in the dental coverage. I understand that in the event I desire dental coverage at a later date, I may be required to furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, and the Company shall have the right to refuse any request.

Enrollee' Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\* Spouse also includes the Insured's state registered domestic partner or civil union partner as defined by state law.*

**NOTICE TO ENROLLEE – DETACH AND GIVE TO ENROLLEE**

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.

**Please See Pages 2 - 4 for Companion Life Insurance Company Fraud Notices**

**FRAUD NOTICE**

**General Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kansas:** Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim 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.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Massachusetts:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN R.S.A. 638:20.

**New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Vermont:** Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

**Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.