Group Enrollment

Please print clearly in blue or blank ink.

Carrier Name.

Group Name **Group Number** **Location/Division**

A. Type of Activity – To be completed by Employer. (Please print clearly.)

1. Check one: Enrollment ☐ New Enrollee/Member Effective Date ____/____/____ Date of Hire ____/____/____

2. Change – Check all that apply

		Date of Event	**Reason**
☐	Add Spouse/Civil Union Partner/Domestic Partner	____/____/____	
☐	Add Dependent Children	____/____/____	
☐	Name Change	____/____/____	
☐	Change Plan	____/____/____	
☐	Add/Change Office ID Numbers: Dentist	____/____/____	

(Make changes in Section C which apply to prepaid plans.)

3. Remove or Terminate – Check all that apply

		Effective Date	**Reason**
☐	Remove Spouse/Civil Union Partner/Domestic Partner*	____/____/____	
☐	Remove Dependent Child*	____/____/____	
☐	Employee/Withdrawal/Termination	____/____/____	

NOTE – Employee must be enrolled for spouse/dependent child(ren) to have coverage. This allows for continued coverage after employment coverage ends. (COBRA – Federal; NJSGC – State)

***Please complete Name and Add/Remove/Other/Continue columns in Section D.**

4. Coverage Continuation with COBRA/NJSGC	**Length of Continuation (in months)**	**Date of Loss of Coverage:**	**Qualifying Event #:**	**Date of Qualifying Event:**	**Billing: Group**	**Billing: Home (What address?)**
☐ Employee	☐ 18 ☐ 29	___/___/___		___/___/___	☐	☐ (section B)
☐ Spouse/Civil Union Partner/Domestic Partner	☐ 18 ☐ 36	___/___/___		___/___/___	☐	☐ (section B) or ☐ (section E)
☐ Dependent	☐ 18 ☐ 36	___/___/___		___/___/___	☐	☐ (section B) or ☐ (section F)

B. Employee Information – To be completed by Employee. (Please print clearly.)

Employee First Name | MI | Last Name

Address | Apt | City | State | Zip

Social Security Number | Birth Date | Home Phone | Gender ☐ Male ☐ Female

Employer Name | Work Phone | Hours Worked Per Week

Work Address | City | State | Zip | Date of Employment

Other Dental Coverage: ☐ Yes ☐ No *If, "Yes:"* Insurer Name _____ Policy # _____

Other Vision Coverage: ☐ Yes ☐ No *If, "Yes:"* Insurer Name _____ Policy # _____

C. Plan Option – To be completed by Employee. (Please print clearly.)

Check one:

☐ I apply for the following coverage for myself only.

☐ I apply for the following coverage for myself, spouse, civil union partner, domestic partner and dependent child(ren), as listed.

☐ I DECLINE COVERAGE FOR:
☐ Employee ☐ Civil Union Partner ☐ Domestic Partner
☐ Dependent Child(ren)

Select the plan in which you will participate:

☐ Prepaid Plan Provided by Union Security DentalCare of New Jersey, Inc.

☐ Dental Low Plan ☐ Dental High Plan (Provided by Union Security Insurance Company)

☐ Dental Plan (Provided by Union Security Insurance Company)

☐ Vision Plan (Provided by Union Security Insurance Company)

This section only applies to prepaid plans. *(Add/Change Office ID numbers or dentist.)*

Activity: ☐ Add ☐ Remove ☐ Continuation ☐ Other change *If a name change, indicate prior name*

Current patient? ☐ Yes ☐ No

Dentist Name Facility ID # *(required)* _____

Address: _____ Zip Code _____

D. Other Individuals Covered – To be completed by Employee. (Please print clearly.)

Identify individuals other than yourself for whom you are adding/removing/continuing coverage. Attach additional pages if necessary, with your signature and date. Attach proof if full-time post-secondary student.

Do you have eligible dependents? ☐ Yes ☐ No If "Yes," complete below to enroll them

Spouse; Domestic or Civil Union Partner Name	(A)dd, (R)emove, (C)ontinue, Spouse Civil Union Partner (NJSGC) Domestic Partner (NJSGC)	Social Security Number	Gender (M) (F)	Birthdate mm/dd/yy	Dentist Name & ID # *(required for prepaid only)*	Current Patient? (Y) (N)	Employed? (Y) (N) (If yes, complete section E.)
Dependent (Child(ren) Name(s)	(A)dd, (R)emove, (C)ontinue, Son Daughter Other	Social Security Number	Gender (M) (F)	Birthdate mm/dd/yy	Dentist Name & ID # *(required for prepaid only)*	Current Patient? (Y) (N)	Living with employee? (Y) (N) (If no, complete section F.)

If the last name of the dependent(s) is different from the employee's, please explain:

E. Additional Spouse/Civil Union/Domestic Partner Information – To be completed by Employee. (Please print clearly.)

Provide information below about children listed in Section D, if they have a different address from the employee.

Employer Name

Employer Address	City,	State	Zip Code	Employer Phone

Home or billing address same as employee? ☐ Yes ☐ No *If "no," complete below.*

Address	Apt	City,	State	Zip Code

Group Name	Group Number	Location/Division

F. Additional Dependent (Child(ren) Information – To be completed by Employee. (Please print clearly.)
Provide information below about children listed in Section D, if they have a different address from the employee.
If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s)	Name(s)
Street/apt	Street/apt
City, State, Zip	City, State, Zip
Reason for difference	Reason for difference

G. Employee Signature – I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Employee Signature (Required) _____ Date ___/___/___

E-mail Address _____

H. Conditions of Enrollment – Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Union Security Insurance Company or Union Security DentalCare of New Jersey, Inc., or any consumer reporting agency acting on behalf of Union Security Insurance Company or Union Security DentalCare of New Jersey, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Union Security Insurance Company or Union Security DentalCare of New Jersey, Inc. has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Union Security Insurance Company or Union Security DentalCare of New Jersey, Inc. will provide coverage in accordance with the terms of the contract for the group plan or policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan or policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

I. Employee Signature – To be completed by Employer.

Employee Signature (Required) _____ Date ___/___/___

Title _____

Coverage must be verified with the appropriate company Union Security Insurance Company or Union Security DentalCare of New Jersey, Inc., based on the Plan Option selected in section C.

Instructions

Employers – Your must complete the Employer Group Information and sections A and I in order for this application to be processed

Employees – You must complete sections B through G in order for this application to be processed

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours

C2. Employee enrollment in Medicare (COBRA only)

C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)

- Please PRINT except when a signature is requested.
- If a dependent experiences a qualifying event and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC election. Instead, select “Other” in Section A3, and attach proof of the event.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.
- DENTAL: For provider addresses, include the zip code plus the four digit extension (11 digits)
- DENTAL: You can obtain the dentists correct names and addresses from the appropriate directory of dentists. You may also obtain each dentist’s facility ID number from the directory or by contacting the provider directly.

C4. Death of Employee

C5. Loss of dependent child status under the plan

Employee Application

Please print clearly in blue or black ink.

ISSUE
Check one – Employer Use

☐ New Employee ☐ Change ☐ COBRA

Employee Information – *Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.*

Employee name (*last, first, initial*)	Employer	Employment location	

Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate

Sex	Job title or position	Employee hire date	# hours per week	Earnings $ _____	Married/Partnered	Children
☐ M ☐ F				☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other _____	☐ Yes ☐ No	☐ Yes ☐ No

Address	City	State	Zip

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

Dependent Information – ***Required if Dependent coverage applies***

Name (Last name, First Name)	Date of Birth	Gender	Relationship

NOTE – *Coverage not elected will be assumed refused even if not specifically refused*

"Civil Union Partner" means partners in a same-sex relationship, whatever it may be called, from another jurisdiction which provides substantially all of the rights and benefits of marriage.

"Domestic Partner" means partners in a same-sex relationship, whatever it may be called, from another jurisdiction that provides some, but not all of the rights and obligations of marriage.

Benefits
You may select the benefits below.

☐ Employee Life ☐ Voluntary Life Amount Electing _____
Have you used tobacco in any form in the last 12 months? ☐ Yes ☐ No

☐ Employee AD&D ☐ Voluntary AD&D Amount Electing _____

Group Name **Group Number** **Location/Division**

☐ Dependent Life ☐ Voluntary Spouse Amount Electing _____
Name of Spouse _____
Date of birth _____
Has your spouse used tobacco in any form in the last 12 months? ☐ Yes ☐ No
☐ Voluntary Child ☐ $1,000 ☐ $5,000 ☐ $10,000

☐ Short Term Disability ☐ Voluntary STD Amount Electing _____

☐ Long Term Disability ☐ Voluntary LTD Amount Electing _____

☐ Critical Illness: ☐ Level 1 ☐ Level 2 (includes cancer option)
☐ Employee Critical Illness Amount Electing _____
Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No
☐ Spouse Critical Illness Amount Electing _____
Has your spouse used tobacco in any form in the past 12 months? ☐ Yes ☐ No
☐ Child(ren) Critical Illness Amount Electing _____

☐ Cancer: ☐ Level 1 ☐ Level 2
☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family
Have you used tobacco, in any form in the past 12 months? ☐ Yes ☐ No

☐ Accident ☐ Employee
☐ Spouse - Include Spouse Off the Job Disability Benefit? ☐ Yes ☐ No
☐ Child(ren)

Beneficiaries - *Applies to all coverages for which a beneficiary designation is required*

Last Name	First	MI	Relationship	
				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.

1) Give FULL names and relationships of each beneficiary.
2) Beneficiaries elected will apply to all coverage elected on this form for which a beneficiary designation is required.
3) If primary/secondary election is not noted, the beneficiary will be considered primary.
4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries.
5) If your designation does not fit in the above arrangement, or you want to specify a beneficiary by coverage, please contact Union Security Insurance Company for the appropriate forms.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company.
(2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company.
(3) Authorize any required deductions from my earnings.
(4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death.
(5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
(6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.
(7) Understand that coverages include limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Employee's signature _____ Date _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____