

Group Insurance Enrollment Card

Freedom Advance Dental Plan



ASSURANT Employee Benefits

Check one – Employer Use

Initial Employee:

Transfer from Prior Dental

Non-Transfer

New Employee

Date of Hire _____

Change

Open Enrollment

(Please print clearly.)

Employer O R NURSES INC C907	Effective Date	Location/Division
Employee First Name	MI	Last Name
Address	City	State
		Zip
Social Security No.	Birthdate	Phone
		Sex <input type="checkbox"/> M <input type="checkbox"/> F

DENTAL COVERAGE

I APPLY FOR:

- Employee only
- Employee and eligible dependents

I DECLINE COVERAGE FOR:

- Employee
- Spouse
- Child(ren)

Do you have eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete below to enroll them.			Birthdate			For children age 19 or older, indicate if a full-time student.	
	Relation	Sex	Mo	Day	Year	Yes	No
Spouse							
Child(ren)							

- List additional Children on reverse side and check box.
- If the address of any child is different than the employee's address, please show that **child's name and address** below.
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- If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Union Security Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the employer named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an active full-time employee of that employer. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Date _____ Signature _____