insuringsmiles.com
PO Box 659 Evansville, IN 47704-0659
800-727-1444 Fax: 812-424-2096

HRI DENTAL & VISION

ENROLLMENT APPLICATION

ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES, AND PROCESS CLAIMS

Group Legal Name:	Group Number:	Site Location:	Plan:

ADD	TERM	UPDATE
Coverage Effective Date:______________	Coverage Termination Date:______________	Event Date (if applicable):______________
☐ Open Enrollment	☐ Open Enrollment	☐ Name Change
☐ New Hire	☐ Employment Termination (circle one) Voluntary Involuntary	☐ Social Security Number
☐ Coverage Lost	☐ Coverage Gained	☐ Date of Birth
☐ Marriage	☐ Death	☐ Address
☐ Divorce or Legal Separation	☐ Reduction of Hours Worked	☐ Coordination of Benefits
☐ Birth/Adoption	☐ Divorce or Legal Separation	☐ Disability
☐ COBRA (if applicable)	☐ Over Age Limit	☐ Full-Time Student Status
	☐ No Longer Full Time Student	
	☐ COBRA (if applicable)	

EMPLOYEE	PRODUCT				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental & Vision ☐ Waive	Social Security Number	Employee Hire Date	Email	
		Last Name	First Name	MI	Birth Date
		Home Address	City	State	Zip

SPOUSE/ PARTNER	PRODUCT				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental & Vision ☐ Waive	Social Security Number	Birth Date		Other Coverage? ☐Yes ☐No
		Last Name	First Name	MI	
		Email			Is Other Policy Primary? ☐Yes ☐No

DEPENDENT	PRODUCT				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental & Vision ☐ Waive	Social Security Number	Birth Date		Other Coverage? ☐Yes ☐No
		Last Name	First Name	MI	
		Email			Is Other Policy Primary? ☐Yes ☐No

DEPENDENT	PRODUCT				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental & Vision ☐ Waive	Social Security Number	Birth Date		Other Coverage? ☐Yes ☐No
		Last Name	First Name	MI	
		Email			Is Other Policy Primary? ☐Yes ☐No

DEPENDENT	PRODUCT				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental & Vision ☐ Waive	Social Security Number	Birth Date		Other Coverage? ☐Yes ☐No
		Last Name	First Name	MI	
		Email			Is Other Policy Primary? ☐Yes ☐No

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 30 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

Fraud Notice: IN: 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. **KY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **OH and IA:** Any person who, with intent to defraud or that he is facilitating fraud against an insurer submits an application or files a claim containing a false deceptive statement is guilty of insurance fraud.

Employee ____ Date ______________

Employer Benefits Administrator/Authorized Agent ______________________ Date ______________