Employee Enrollment Form

DentalSelect

Use the Employee Enrollment Form to collect first time employee and dependent information. For existing member changes, please use the Employee Change Form.

Must Be Completed in Full - PLEASE PRINT

First Name	Last Name	M.I.
Address		
City	State	Zip Code
Phone # ☐ OK to Text	Date of Birth (MM/DD/YYYY)	
Email Address		
SSN	Marital Status ☐ Married ☐ Single	Gender ☐ Male ☐ Female
Effective Date (MM/DD/YYYY)	Date of Hire (MM/DD/YYYY) **(Required)**	
Group Number	Subgroup/Department	
Name of Employer		
Employer's Address		

Authorization of Coverage

☐ Check here to waive if no coverage is desired

☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claims and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

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.

Fraud Warning for Texas Applicants: WARNING: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE US OR ANY OTHER PERSON, MAKES A REQUEST FOR INSURANCE CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIME.

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, I will not be entitled to any compensation for my non-participation.

CHUBB®

All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

Plan/Coverage – Confirm available options with your employer. Select all that apply.

Dental Plan	☐ PPO	☐ High	☐ Low	☐ Co-Pay	☐ High Deductible
Network	☐ Gold	☐ Platinum			
Vision Plan	☐ Vis 6	☐ Vls 8	☐ Vis 12	☐ Vis 21	☐ Other _____
AD&D	☐ Employee	☐ Employee + Dependants	Amount $_____		

If elected, please also complete a Beneficiary Designation form.

Individuals Covered – List individuals and select plan options for whom you are enrolling

☐ Dental ☐ Vision	Spouse Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	

For additional dependents, attach separate sheet.

☐ I am eligible for enrollment based on a qualifying life event.

Qualifying Event _____ Date of Event_____

☐ I am eligible for waiting periods to be waived and have met the necessary requirements.

Waiver Requirements:

- Require CCL (Credible Coverage Letter) within 45 days
- Less than 60 day lapse in coverage from a prior dental plan
- Prior comparable plan summary (submitted within 45 days)
- Orthodontic services may not be eligible (unless prior coverage included Orthodontic services)

Signature Date

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070
800-999-9789 • Toll Free Fax: 888-998-8704

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