Texas Group Enrollment Card

DENTALSELECT
The power 2 choose

65 Wadsworth Park Drive, Suite 200
Draper, UT 84020-8157
(800) 999-9789 (801) 495-3000
Toll Free Fax (888) 673-5328
Fax (801) 495-3368

Employee Information - Must be Completed in **FULL**

Last Name | **First Name** | **Middle Initial**

Street Address

City | **State** | **Zip Code**

Home Phone | **Date of Birth**

SSN

Marital Status Married ☐ Single ☐ | **Sex** Male ☐ Female ☐

Employers Full Name | **Employers Address**

☐ **New Enrollee** ☐ **Change** **Group Number** _____

Effective Date | **Date of Hire**

Coverage Selections - Confirm available options with your employer. Vision and Accident coverage are available if your employer elected to provide that coverage. Check all that apply.

Dental - Select one.
- ☐ **Silver**
- ☐ **Gold**
- ☐ **Platinum PPO**
- ☐ **Platinum Indemnity**

Vision - Select one.
- ☐ **Access Vision**
- ☐ **Preferred Plus**
- ☐ **Premier**
- **Premier Plus**
  - ☐ Option 1 ☐ Option 2 ☐ Option 3

AD&D - Select one.
- ☐ **Employee** (must complete information below) ☐ **Decline**
- ☐ **Employee + Family** (must complete information below)
- ☐ **AD&D Voluntary** Amount _____

Beneficiary Information - Full Name (First, Middle, Last)

Beneficiary SSN | **Relationship to Employee**

Visit us online at: **dentalselect.com**

[redacted]

TX2005 GEC 05/05

Texas Group Enrollment Card (cont.)

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Individuals Covered - List individuals for whom you are enrolling or adding/removing coverage.

	Sex	SSN	DOB MM/DD/YYYY	Dental	Covered by other DENTAL insurance? Carrier Name	Effective Date	Policy Holder	Vision
Spouse Name- (Last, First, MI)	☐ Male ☐ Female			☐ Enroll ☐ Decline				☐ Enroll ☐ Decline
Child Name- (Last, First, MI)	☐ Male ☐ Female			☐ Enroll ☐ Decline				☐ Enroll ☐ Decline
Child Name- (Last, First, MI)	☐ Male ☐ Female			☐ Enroll ☐ Decline				☐ Enroll ☐ Decline
Child Name- (Last, First, MI)	☐ Male ☐ Female			☐ Enroll ☐ Decline				☐ Enroll ☐ Decline

Attach additional sheets if necessary.

Covered by other DENTAL insurance? ☐ Yes ☐ No

If Yes, Name of Other Dental Insurance Company | Name of Person Insured | Social Security Number

☐ **Check here to waive if no coverage is desired** ☐ **Check here to waive if you have additional coverage through another policy**

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, that I will not be entitled to any compensation for my non-participation. I further understand I will not be eligible to enroll in this plan again until next enrollment period.

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 claim 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.

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.

Signature | **Date**

ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE American Insurance Company.

ace usa