

**Idaho Dental Only  
ENROLLMENT  
APPLICATION**



Please write legibly in black or blue ink. Complete all applicable sections.

Group Policy No.	Subgroup No.	Class No, Classification, or Plan Design
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**Section 1 – Enrollment Information**

Employer/Group Name	Effective Date month _____ day _____ year _____
Date of Full Time Hire (required) month _____ day _____ year _____	Number of Hours Worked Per Week
Are you an owner of this company? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Section 2 – Employee Information**

Employee Last Name	First Name	M.I.
Mailing Address	City	State Zip code
Home Phone No.	E-Mail Address	Job Title
Date of Birth month _____ day _____ year _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____

**Type:**  New Applicant–Employee  Add dependents  COBRA–qualifying event \_\_\_\_\_  
**Due To:**  New Hire  Marriage  Birth  Adoption\*  Court Order\*  Involuntary loss of other coverage\*  
**Date Qualifying Event Occurred:** month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ *\*Attach proof of qualifying event*

**Section 3 – Employee and Family Members You Wish to Enroll**

**\*Race / Ethnicity** (choose the code each family member would most closely identify with): **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

Name	Gender	Birth Date	Social Security Number	*Race / Ethnicity
Employee				
Spouse				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				

If you or your spouse are a court-ordered guardian of any dependent listed above, please identify and provide proof:  
 Name(s): \_\_\_\_\_ Type:  Grandchild  Niece/Nephew  Sibling  Other \_\_\_\_\_

Primary language spoken in household:  English  Español  Other: \_\_\_\_\_  
*Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m*

### Section 4 – Other Coverage

**Current or Prior Coverage Information** – Do you or any person listed on this application have or have had dental insurance in the last 24 months? No Yes If yes, complete the following **and** attach proof with dates of coverage.

Name(s)	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

**Child** – Is any child listed on this application eligible to enroll in any other employer-sponsored group dental plan as an employee or spouse? No Yes If yes, list name(s):

**Spouse** – Is your spouse employed? No Yes If yes, self employed? No Yes

### Section 5 – Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. List court ordered coverage in Section 4.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	If Court Order, Name Responsible for Insurance
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				

### Section 6 – Acknowledgement and Declaration

I understand that dental and medical late enrollment provisions are different and not impacted by the other. An employee or dependent that did not enroll in the dental plan within the 31-day initial enrollment period and does not qualify for a special enrollment period may enroll later on the policy's anniversary date. An employee or dependent that enrolled on the dental plan and later discontinued coverage may re-enroll in the plan on an anniversary date of the policy following a 24-month waiting period from the date coverage was discontinued.

I acknowledge and understand that my plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating dental or health care treatment, payment, or for business operations necessary to administer dental care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner; a clinic, hospital, long term care, or other medical facility; any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or an insurer or group health plan.

Information requested or disclosed may include, but not limited to: claims records, correspondence, dental or medical records, billing statements, diagnostic imaging reports, laboratory reports, or hospital records (including nursing records and progress notes).

As proof of status of employment, I authorize my employer to release to PacificSource appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.

Unless revoked earlier, this authorization will be valid for sixty (60) days after the date it is signed. I understand that I can revoke this authorization at any time by giving written notices to PacificSource. I understand that this application will become part of the contract between PacificSource and my employer. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may not be protected by federal rules governing privacy and confidentiality.

I have reviewed all answers and, regardless of whether a producer or other person has completed the answers for me, I affirm that the answers on this application are true and complete. PacificSource may terminate or rescind an employer's group coverage for any revocation or misrepresentation or omission of fact that would have been material in acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**