

ALLIED

BENEFIT SYSTEMS, INC.

ENROLLMENT FORM - DENTAL

SECTION 1: FOR ABS USE ONLY.		EFFECTIVE DATE	EMPLOYMENT DATE	TERMINATION DATE
SECTION 2: PLEASE COMPLETE THE SECTION BELOW.				Group # A01195
GROUP NAME North Suburban Library System	LOCATION	EMPLOYMENT DATE	DATE INSURANCE WAITING PERIOD BEGAN - IF DIFFERENT:	
<input type="checkbox"/> NEW ENROLLEE <input type="checkbox"/> LATE APPLICANT <input type="checkbox"/> SPECIAL ENROLLMENT (SEE REVERSE) <input type="checkbox"/> CHANGE IN A CURRENT MEMBER'S STATUS				
SOCIAL SECURITY NUMBER		APPLICANT NAME (PLEASE PRINT)		
STREET NUMBER		CITY	STATE	ZIP
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	DATE OF BIRTH	(Area) PHONE NUMBER	
PLEASE SELECT: DENTAL: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Family				
SECTION 3: COMPLETE THE FOLLOWING IF APPLYING FOR DEPENDENT COVERAGE.				
(Dependents must be listed below to be eligible for coverage)				
NAME OF DEPENDENT	RELATIONSHIP	GENDER	DATE OF BIRTH	SOCIAL SECURITY NO.
Spouse:	SPOUSE			
Dep 1:				
Dep 2:				
Dep 3:				
Dep 4:				
DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER GROUP DENTAL? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:				
NAME OF INDIVIDUAL WITH OTHER COVERAGE		INSURANCE CARRIER OR TPA		
STREET NUMBER OF CARRIER OR TPA		CITY	STATE	ZIP
WAIVER OF COVERAGE: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Family <input type="checkbox"/> ARE YOU DECLINING DUE TO COVERAGE UNDER ANOTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF BLANK, THE PLAN WILL ASSUME "NO") IF YES, IS THIS OTHER COVERAGE COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER (PLEASE EXPLAIN) _____				
IMPORTANT NOTICE				
If you refuse coverage for yourself, you automatically refuse that coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of other Dental Insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.				
The pre-existing conditions limitation is stated in the summary plan description. You and/or your dependants have the right to demonstrate creditable coverage by requesting a certificate of coverage from your prior plan or insurer. If necessary and requested, this plan will assist you in obtaining this certificate.				
I certify the above information is true and correct.				
SIGNATURE OF EMPLOYEE		DATE SIGNED		

***IF APPLYING FOR COVERAGE UNDER THE SPECIAL ENROLLMENT RULES, PLEASE COMPLETE THE REVERSE SIDE**

SPECIAL ENROLLMENT:

HIPAA permits a special enrollment period for an employee (or dependent), who is eligible for coverage, but not enrolled, to enroll if the employee (or dependent) had other coverage and loses it, or if a person becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption. A person who enrolls during a special enrollment period is not treated as a late enrollee.

CHECK ALL THAT APPLY

- I am adding coverage for myself
- I am adding coverage for my spouse
- I am adding coverage for my dependent children

CONDITIONS FOR SPECIAL ENROLLMENT (Check all that apply)

- 1. Loss of Other Coverage (Attach certificate of coverage)
 - Divorce
 - Legal separation
 - Death
 - Termination of employment
 - Reduction in hours
 - Other (Please Explain) _____
- 2. COBRA coverage exhausted (Attach certificate of coverage)
- 3. Marriage
- 4. Birth of a child
- 5. Adoption

I hereby submit application for coverage under my employer group health plan through special enrollment. I certify that the above information is true and accurate.

SIGNATURE OF EMPLOYEE

DATE SIGNED