



Enrollment/Change Form DENTAL & VISION INSURANCE

Underwritten by Starmount Life Insurance Company
Administered by: AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)
7800 Office Park Boulevard Baton Rouge, LA 70809-9100
1-888-729-5433, Ext 2013 (in Baton Rouge, call 926-2888)

Please print and complete all sections.

GROUP/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)					
Group Name Southern Medical Corporation		Group Number SOU904	Location	Effective Date	Date of Hire
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name	First Name	M.I.	Date of Birth	Social Security Number
Home Street Address		City/State/Zip	Home Phone ()		Work Phone ()
Email Address					Cell Phone ()

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)					
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE for Dental: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.

NOTE for Vision: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for 12 months.

Employee Signature: _____ Date: _____

I elect the following coverage(s):

- | | |
|---|---|
| <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee Only |
| <input type="checkbox"/> Employee Family | <input type="checkbox"/> Employee Family |
| <input type="checkbox"/> Waived due to other coverage | <input type="checkbox"/> Waived due to other coverage |
| <input type="checkbox"/> Waive | <input type="checkbox"/> Waive |

Do you or any of your dependents have other [dental or vision] insurance? Yes No

If yes, please give: Policyholder _____ and Insurance Company _____.

Declination of coverage must be accompanied by the Employee's signature above.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.