# GROUP DENTAL EMPLOYEE ENROLLMENT FORM

**NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).**

**Administered by:**
Companion Life Insurance Company
800 Main Street, P.O. Box 1535
Dubuque, IA 52004-1535
Telephone Number: 877-676-5789
Fax: 563-557-3351

**Underwritten by:** Companion Life Insurance Company

Companion Life

P.O. Box 100102 | Columbia, SC 29202-3102
800-753-0404 (Phone) | 800-836-5433 (Fax)

| **Companion Life Insurance Company** | | | **Companion Life Use ONLY** |
|---|---|---|---|
| □ New Employee | □ Change Address | □ COBRA | Approved: □ Declined: □ |
| □ Add/Increase Coverage | □ Change Dependent Coverage | | Date: _____ |
| | □ Change Class or Status | | By: _____ |
| | □ Terminate Coverage | | |

**POLICYHOLDER INFORMATION – to be completed by the Policyholder or Group Administrator**

Employer Name:_____ DBA:_____

Group Number:_____ Dept/Div Number:_____ Class:_____

**ENROLLEE INFORMATION (PLEASE PRINT)–to be completed by the Employee/Enrollee**

| Last Name (Include Jr., Sr., etc.) | First Name | | M.I. |
|---|---|---|---|
| Street Address | Apt Number | City | State/Zip |
| Social Security Number | Primary Phone Number<br>Work Phone Number | | Email Address |
| Male ☐ Female ☐ | Date of Birth(MM-DD-YY)<br>/ / | ☐ Weekly ☐ Monthly ☐ Annually<br>Earnings$_____ Do not include overtime or bonuses | |
| Marital Status<br>☐ Single<br>☐ Married | Occupation | Hours Worked Per Week _____ | Hire Date: / /<br>Coverage Effective Date: / / |

**PLAN AND COVERAGE SELECTION**

☐ Employee ☐ Employee + Spouse ☐ Employee + Children ☐ Family

| **DEPENDENT INFORMATION (please attach additional pages as needed)** | | | **Do any of your Dependents have any other dental coverage?** |
|---|---|---|---|
| Spouse Name | □ Male □ Female | Date of Birth (MM-DD-YY)<br>/ / | □ Yes Name of Carrier<br>□ No |
| Child Name | □ Male □ Female | Date of Birth (MM-DD-YY)<br>/ / | □ Yes Name of Carrier<br>□ No |
| Child Name | □ Male □ Female | Date of Birth (MM-DD-YY)<br>/ / | □ Yes Name of Carrier<br>□ No |
| Child Name | □ Male □ Female | Date of Birth (MM-DD-YY)<br>/ / | □ Yes Name of Carrier<br>□ No |
| Child Name | □ Male □ Female | Date of Birth (MM-DD-YY)<br>/ / | □ Yes Name of Carrier<br>□ No |

**DEPENDENTS:** Eligible Dependents are determined by your Employer's eligibility terms.

***If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Enrollee.***

**AUTHORIZATION FOR DEDUCTION**

I ☐ agree ☐ do not agree to have the certificate documents delivered to the Policyholder electronically.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages. I affirm, to the best of my knowledge and belief, that all information given by me on this form is true and complete. I have read or had read to me any Fraud notice below applicable to my state of issue of this enrollment form.

**Enrollee's Signature:**_____ **Date:**_____

**REFUSAL/WAIVER – Complete ONLY if you are declining coverage.**

I have been offered insurance coverage as permitted by my Employer and decline to participate in the dental coverage. I understand that in the event I desire dental coverage at a later date, I may be required to furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, and the Company shall have the right to refuse any request.

**Enrollee' Signature:**_____ **Date:**_____

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**Please See Page 2 Companion Life Insurance Company Fraud Notices**

**FRAUD NOTICE**

**New Mexico**: 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 CIVIL FINES AND CRIMINAL PENALTIES.