



KANAWHA
HealthCare
 SOLUTIONS, INC.

General Synod of the Associate Reformed Presbyterian Church
 Group Dental Enrollment Form

Submit Form To
 Associate Reformed Presbyterian Center
 1 Cleveland Street, Suite 110
 Greenville, SC 29601-3696

PLAN NUMBER: GAR0801					
A. Employer Information					
Employer Name/Company Name (Please Print) AGENCY or CHURCH: _____				County _____	State _____
B. Employee Information					
Social Security Number _____		Last Name _____		First Name _____ MI _____	
Street Address _____		City _____	State _____	Zip _____	Date of Birth _____
<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Spouses Date of Birth _____		Home Phone () _____	Work Phone () _____
C. Employment Information					
Occupation: _____		Date of Full-Time Employment: _____		Average Hours Worked Per Week: _____ <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	
D. Coverage Category: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus 1 <input type="checkbox"/> Family <input type="checkbox"/> None (Complete Waiver)					
E. Eligible Dependents to be Enrolled (To be Completed by Employee)					
Name		Reside With Employee	Sex	Date of Birth	Social Security #
Spouse:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
F. Other Coverage Information (To be Completed by Employee)					
Are you or any member of your family covered by any other dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, Name of Carrier: _____					
Policy ID # _____					
Address _____					
Policy Holder Name: _____					
Are Family Members Covered: <input type="checkbox"/> Yes <input type="checkbox"/> No					
G. Acceptance and Authorization for Coverage and Participation: I certify that the above information is correct and true to the best of my knowledge and that the children listed above either live with me in a normal parent-child relationship or are legally dependent upon me for their support. I hereby authorize any hospital or physician to release information to process claims on myself and any dependents on this Plan. Employee's Signature: _____ Date Signed: _____					
H. Refusal: The benefits have been explained to me and I have refused to participate in the plan. I have signed the attached Waiver of Coverage. Employee's Signature: _____ Date Signed: _____					
I. Employer Certification: The above information is correct and true to the best of my knowledge. Employer's Representative Signature: _____ Date Signed: _____					
J. Coverage Information (To be Completed by Group Administrator, Board of Benefits)					
Effective Date of Coverage: _____		Experience Category _____			
Was Subject to 90 Day Waiting Period: <input type="checkbox"/> Yes <input type="checkbox"/> No		_____			
Hire Date: _____					
K. Group Administrator Certification: The above information is correct and true to the best of my knowledge. Group Administrator's Signature: _____ Date Signed: _____					

WAIVER OF COVERAGE

The group **dental program** has been offered to me, and after carefully considering its benefits, I have decided:

- (a) not to enroll myself in the Dental Program
 - (1) I am covered as a Dependent Spouse in another Plan
 - (2) I had other Creditable Coverage when I became eligible for this Plan
 - (3) I am not covered in another Plan
- (b) not to enroll my dependents in the Dental Program
 - (1) My Dependents are covered in another Plan
 - (2) My Dependents are not covered in another Plan

I understand that if I do not enroll myself and/or my eligible Dependents in the **group dental program** at this time and do not meet the eligibility for **Special Enrollment**, as outlined below,

- (1) I will be able to enroll and/or add dependents only during the **group dental program** Open Enrollment period, currently in December for coverage to begin January 1 **and**
- (2) benefits during the first 12 months of coverage will be limited to initial and periodic exams, x-rays, cleanings and fluoride applications only.

Special Enrollment: In the event a person becomes my Dependent through marriage, birth, adoption or placement for adoption (all other Dependents must be enrolled at the same time) **OR** I had waived coverage on the basis of item (b)(1) above and my Dependent or Dependents lose coverage as a result of loss of eligibility under another group plan and

I request enrollment of such person or persons within 31 days of the qualifying event, enrollment will be permitted at the time of such occurrence and restrictions on coverage will not apply.

I understand that if the other coverage is lost as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim) these options will not be granted.

Employee Signature

Date Signed

Employee Printed Name