

CITY OF VENICE
Group Dental Insurance Enrollment/Change Form

Section 1: Personal Information					
Employee Name (Last, First, MI)		Social Security No.	Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Home Street Address		City	State	Zip Code	Telephone No.
Section 2: New Enrollment					
<input type="checkbox"/> ADD	Coverage Level: <input type="checkbox"/> Empl/Ret Only <input type="checkbox"/> Empl/Ret + 1 <input type="checkbox"/> Family		Plan: <input type="checkbox"/> Core Plan (Plan B) <input type="checkbox"/> Plus Plan (Plan A)		Effective Date:
Section 3: Change					
<input type="checkbox"/> CHANGE COVERAGE to <i>Must complete Section 4 below</i>		<input type="checkbox"/> CHANGE PLAN to		Effective Date:	
<input type="checkbox"/> Empl/Ret Only <input type="checkbox"/> Empl/Ret + 1 <input type="checkbox"/> Family		<input type="checkbox"/> Core Plan (Plan B) <input type="checkbox"/> Plus Plan (Plan A)			
<input type="checkbox"/> DROP ALL DENTAL COVERAGE		<input type="checkbox"/> DROP DEPENDENT <i>Complete Section 4</i>		<input type="checkbox"/> ADD DEPENDENT <i>Complete Section 4</i>	
Section 4: Dependent Information (Attach additional sheet of paper, if necessary. Sign and date it.)					
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship SPOUSE
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
Section 5: Other Coverage (Attach additional sheet of paper, if necessary, Sign and date it.)					
Do any dependents listed above have Dental insurance under another group plan? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes for each dependent with other coverage, please provide:					
Name of Dependent with Other Coverage		Group Plan Name & No.	Insured Member Name	Insured Member Birthdate	
Name of Dependent with Other Coverage		Group Plan Name & No.	Insured Member Name	Insured Member Birthdate	
Name of Dependent with Other Coverage		Group Plan Name & No.	Insured Member Name	Insured Member Birthdate	
Section 6: Acceptance/Declination of Coverage					
<input type="checkbox"/> I wish to apply for coverage as indicated above. I have read and accept the "Acceptance of Coverage" on the reverse side of this form. I hereby certify that the statements on this application, including any attachment to it, are true and complete.			<input type="checkbox"/> I do not wish to apply for any coverage. I understand that if I decide to apply at a later time, coverage may not be available until the next open enrollment.		
Section 7: Signature					
Employee Signature				Date	

Acceptance of Coverage

Please Read Before Signing the Front Side of this Form

I hereby apply for the coverage indicated on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. if my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of 1. all effective dates; 2. all termination dates; 3. any COBRA or ERISA rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If coordination of benefits applies for me and my dependents and an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that if I apply for FCL coverage later, coverage will not be available until the next open enrollment.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

I agree to be bound by the group contract's terms and conditions.