

Texas Employee Enrollment Card



5373 S. Green Street, Suite 400
Salt Lake City, UT 84123
(800) 999-9789 (801) 495-3000
Toll Free Fax (888) 998-8704
Fax (801) 290-5101

Employee Information - Must be completed in FULL

Last Name		First Name		Middle Initial
Street Address				
City		State	Zip Code	
Home Phone		Date of Birth		
SSN				
Marital Status		Sex		
Married <input type="checkbox"/> Single <input type="checkbox"/>		Male <input type="checkbox"/> Female <input type="checkbox"/>		
Employers Full Name		Employers Address		

<input type="checkbox"/> New Enrollee	<input type="checkbox"/> Change <small>(For Open Enrollment Only!)</small>	Group Number
Effective Date		Date of Hire (Required)

Coverage Selections - Confirm available options with your employer. Check all that apply.

Dental - Select one <input type="checkbox"/> Discount Silver <input type="checkbox"/> Co-Pay Gold <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> Co-Pay Platinum <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> PPO Gold <input type="checkbox"/> PPO Platinum <input type="checkbox"/> Indemnity PPO Platinum <input type="checkbox"/> Traditional	Vision - Select one <input type="checkbox"/> Access Vision <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Premier Premier Plus <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3
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AD&D - Select one <input type="checkbox"/> Employee (must complete information below) <input type="checkbox"/> Decline <input type="checkbox"/> Employee + Family (must complete information below) <input type="checkbox"/> AD&D Voluntary Amount \$ _____

Beneficiary Information - Full Name (First, Middle, Last)	
Beneficiary SSN	Relationship to Employee

Individuals Covered - List individuals for whom you are enrolling or adding/removing coverage.

Spouse Name- (Last, First, MI)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	DOB MM/DD/YYYY	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Decline	Covered by other DENTAL insurance? Carrier Name Effective Date Policy Holder	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Decline
Child Name- (Last, First, MI)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	DOB MM/DD/YYYY	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Decline	Covered by other DENTAL insurance? Carrier Name Effective Date Policy Holder	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Decline
Child Name- (Last, First, MI)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	DOB MM/DD/YYYY	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Decline	Covered by other DENTAL insurance? Carrier Name Effective Date Policy Holder	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Decline
Child Name- (Last, First, MI)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	DOB MM/DD/YYYY	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Decline	Covered by other DENTAL insurance? Carrier Name Effective Date Policy Holder	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Decline

Attach additional sheets if necessary.

Covered by other DENTAL insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Other Dental Insurance Company	Name of Person Insured	Social Security Number
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- I wish to enroll Check here to waive if no coverage is desired Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

Any person who knowingly, and with intent to defraud or deceive us or any other person, makes a request for insurance containing any false, incomplete or misleading information may be guilty of a crime.

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, that I will not be entitled to any compensation for my non-participation. I further understand I will not be eligible to enroll in this plan again until next enrollment period.

Signature _____ Date _____

ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE American Insurance Company.
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