DENTAL PLAN
NEW JERSEY ENROLLMENT/CHANGE REQUEST

SENTRY® LIFE INSURANCE COMPANY

Employer Group Information - To be completed by Employer.

Group Name | Group Number | Class Code

TO BE COMPLETED BY EMPLOYER

A. Type of Activity - To be completed by Employer. Refer to instructions at the end of this form before completing this form. Print clearly.

1. Enrollment ☐ New Enrollee/Subscriber Effective Date _____ Date of Hire _____

2. Change - Check all that apply

	Date of Event	Reason
☐ Add Spouse/Civil Union Partner		
☐ Add Dependent Child		
☐ Name Change		
☐ Change Plan		
☐ Other _____		
☐ Add/Change Office ID Number		

3. Remove or Terminate - Check all that apply

	Effective Date	Reason
☐ Remove Spouse*/Civil Union Partner*		
☐ Remove Dependent Child*		
☐ Employee Withdrawal/Termination		

NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage (i.e. COBRA, State). Not all options are available or applicable. Contact Employer for available options.

Coverage for ☐ Employee ☐ Dependents

Length of Continuation ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos

Date of Loss of Coverage _____ Date of Qualifying Event _____

TO BE COMPLETED BY EMPLOYEE.

B. Employee Information - Complete sections B-G.

Last name, First name, M.I. _____

Social Security Number _____ Home Telephone ( ) _____

Home address _____ Apt. No. _____ City, State _____ Zip Code _____

Employer name _____ Work Telephone ( ) _____

Work address _____ City, State _____ Zip Code _____

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TO BE COMPLETED BY EMPLOYEE

C. Plan Option – Your selection must be offered by your Employer.

Calendar Year Deductible (check one) ☐ $0 ☐ $50 ☐ $100

Calendar Year Maximum (check one) ☐ $500 ☐ $1000 ☐ $2000

Coinsurance (paid by Sentry for dental services) (check one)

☐ Option A: 80% Preventive / 80% Basic / 50% Major

☐ Option B: 100% Preventive / 80% Basic / 50% Major

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number
Employee					
Spouse/ Civil Union Partner					
Child					
Child					
Child					
Child					
Child					

E. Other/Previous Insurance

Is your spouse/civil union partner employed? ☐ Yes ☐ No

If "Yes", give name and address of your spouse's employer.

_____

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No

If "Yes", who and at what address?

_____

(Explain the circumstances.)

_____

(If any dependent's last name differs from yours, explain the circumstances.)

G. Employee Signature *If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Participant Services representative at phone number 1-800-648-1122 before signing this form.*

I represent that all the information supplied in this application is true and complete to the best of my knowledge and belief. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Employee Signature - Required X_____ Date _____ E-Mail Address _____

H. Employer Verification - To be completed by Employer.

Employer Signature - Required X_____ Title _____ Date _____

Employee copy may be used as a temporary ID card for 30 days from the effective date which is authorized by employer.

Instructions

Employer

- Complete the Employer Group information in the upper right corner of the form.
- Section A - Type of Activity: Check boxes indicating reason(s) for submitting application.
- Complete Section H - Employer Verification in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes, and terminations.
  - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections B-G

Section B - Employee Information

- Complete all information in order for your application to be processed.

Section C – Plan Option

- Select one Calendar Year Deductible box, Calendar Year Maximum box, and Coinsurance Option (if applicable).
- Select only an option offered by your employer.

Section D - Individuals Covered

- Add/Change/Remove - Use “A”, “C”, or “R” to indicate whether you are adding, changing, or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate sex, birthdate, and social security number for each individual listed.
- If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.

Section E – Other/Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan, or Medicare.

Section F – Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature

- Complete this section for all new enrollments, coverage changes, and terminations.
- [Employee] must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section H - Employer Verification

- Employer must complete this section for all new enrollments, coverage changes, and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgment and Agreements

On behalf of myself and the dependents listed above, I agree to or with the following:

1. a) I authorize the sources stated below to give to Sentry, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage and medical advice, treatment, or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic, or other medical care institution; any carrier; any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [carrier] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Sentry group policy, coverage is provided by Sentry in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Sentry.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefits plan is subject to criminal and civil penalties.