100 SW Market Street
P.O. Box 1271 E-3A
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

GROUP MANAGED CARE DENTAL INSURANCE
EMPLOYEE ENROLLMENT FORM- NATA (OR013928)

Please complete all information on this page and on page 2.

EMPLOYER NAME				
☐ New Group ☐ Open Enrollment ☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____ ☐ Change of Existing Enrollment ☐ COBRA ☐ Non-COBRA Continuation of Coverage ☐ Cancelation **For any change to existing enrollment, cancelation, or continuation of coverage, please indicate reason below.**				
Employee's Last Name	Employee's First Name	M.I.	☐ M ☐ F	Date of Birth
Social Security Number	☐ Married / Domestic Partner (Spouse) ☐ Divorced ☐ Single			Telephone Number ( )
Home Address & Apt. No./Mailing Address	City			State Zip

Dependents to be enrolled: Dependent children must be under 26 years of age.

Last Name	**First Name**	**M**	**SS#**	**Birth Date**	**Sex**	**Relationship** (Spouse, Child)
					M / F	
					M / F	
					M / F	
					M / F	
					M / F	

List names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

If changing existing enrollment, indicate reason below:

☐ **Name Change** – Former name _____ ☐ Address Change

Add Dependent(s)

Add Dependent(s) due to ☐ Open Enrollment ☐ Marriage / Domestic Partnership – Date _____

☐ Newborn - Date of Birth _____ ☐ Adoption - Date of Placement in Home _____

☐ Loss of Coverage - Date _____ Reason _____

Name of Prior Carrier _____ Telephone Number _____

Coverage was ☐ Group ☐ Individual ☐ Medical ☐ Dental Prior Policy Number _____

Coverage was for ☐ Self Only ☐ Family as listed above ☐ Other Identification Number _____

Cancelation of Coverage

Delete Dependent(s) due to: ☐ Dependent no longer eligible – Date dependent was no longer eligible _____

☐ Death - Date _____ ☐ Divorce/Term. of Dom. Part. - Date _____

Delete ☐ All Dependents ☐ Dependent(s) Name(s) _____

Please complete page 2 before signing and submitting your Enrollment Form

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Continuation of Coverage

Termination of Coverage was due to: ☐ Termination of Employment ☐ Reduction in hours ☐ Military Leave
☐ Employee's Death ☐ Other _____ Date of Qualifying Event _____

I hereby apply for enrollment with LifeMap Assurance Company under the Group Dental Insurance Policy of the Employer named on Page 1. I hereby authorize the Employer named on Page 1 to withhold insurance premiums, if required, from my paycheck and to pay them directly to LifeMap Assurance Company.

I acknowledge and understand LifeMap Assurance Company may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statement, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

INSURANCE FRAUD WARNING: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all coverage under this Policy will terminate for such Member retroactively to the Effective Date.

▶ _____ ▶ _____
Employee's Full Name (please print clearly) Employee's Signature

▶ _____
Date Signed