Employee Application

Please print clearly in blue or black ink.

SunLife Dental
1-800-442-7742

ISSUE

Check one – Employer Use

☐ New Employee ☐ Change ☐ COBRA

EMPLOYEE INFORMATION—Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

Employee name *(last, first, initial)*	Employer **Davie County Schools**	Employment location

Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate
605355/0				

Sex	Job title or position	Employee hire date	# hours per week	Earnings $	Married	Children
☐ M ☐ F				☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other $_____	☐ Yes ☐ No	☐ Yes ☐ No

Address City State Zip

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

DEPENDENT INFORMATION—Required if Dependent coverage applies

Name (Last Name, First Name)	Date of Birth	Gender	Relationship	Facility ID

NOTE — Coverage not elected will be assumed refused even if not specifically refused

DENTAL BENEFITS— You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

Coverage	EMPLOYEE MONTHLY COST
Employee	☐ _____
Employee + Spouse	☐ _____
Employee + Child(ren)	☐ _____
Employee + Family	☐ _____

☐ **Refuse Dental Benefits**

Were you covered under another dental plan within the last 31 days? ☐ Yes ☐ No

If "Yes," termination date _____ Reason for termination of coverage _____

Union Security Insurance Company
Mail to: P.O. Box 981624 El Paso, TX 79998-1624

ISSUE

Employee name		Employer **Davie County Schools**
Group policy/participant no. **605355/0**	Account no.	Cert. no.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:
(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant Limitation period specified in the policy. (3) Authorize any required deductions from my earnings. (4) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (5) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured. (6) Understand that I have the right to select any dental care provider of my choice. (7) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed. (8) Understand that coverages include waiting periods, limitations, and exclusions that may affect my entitlement to benefits. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

No statement made by you or by you on behalf of a dependent about insurability will be used to deny a claim for a loss incurred after coverage has been in effect for 2 years.

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid. Pursuant to NCGS 58-2-161(b), any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Employee's signature _____ Date _____