*PLEASE PRINT*

# GROUP DENTAL BENEFIT PLAN ENROLLMENT FORM

CORESOURCE
*A Trustmark Company*

| EMPLOYER | OCCUPATION | DEPT | LOCATION | DATE EMPLOYED / / |
|---|---|---|---|---|

| SOCIAL SECURITY # | LAST NAME | FIRST | MI | SEX ☐ M ☐ F | BIRTH DATE / / | EMPLOYEE PHONE # ( ) |
|---|---|---|---|---|---|---|

EMPLOYEE'S HOME ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP)

MARITAL STATUS: (CHECK APPROPRIATE BOX(S) AND FURNISH DATE) ☐ NEVER MARRIED ☐ MARRIED ___/___/___ ☐ WIDOWED ___/___/___
☐ LEGAL SEPARATION ___/___/___ ☐ DIVORCED* ___/___/___ ☐ REMARRIAGE ___/___/___

* **IF EVER DIVORCED AND ENROLLING DEPENDENTS, PLEASE PROVIDE A COPY OF THE PORTION OF ANY DIVORCE DECREE(S) REFERRING TO CUSTODY AND RESPONSIBILITY FOR HEALTH EXPENSES OF ANY DEPENDENTS DIRECTLY TO CoreSource, Inc. BE SURE TO INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND EMPLOYER NAME WITH THE DECREE. ELIGIBILITY FOR YOUR DEPENDENTS CANNOT BE DETERMINED AND CLAIMS WILL NOT BE CONSIDERED FOR PAYMENT UNTIL YOU HAVE RETURNED THE REQUESTED INFORMATION.**

TYPE OF COVERAGE: (CHECK ONE) ☐ INDIVIDUAL (EMPLOYEE ONLY) ☐ EMPLOYEE PLUS ONE ☐ EMPLOYEE PLUS TWO
☐ FAMILY (EMPLOYEE & ELIGIBLE DEPENDENTS) ☐ NO COVERAGE

☐ IF NO COVERAGE HAS BEEN SELECTED, I HEREBY REFUSE THE BENEFIT PLAN OFFERED BY MY EMPLOYER AND UNDERSTAND THAT MY FUTURE ENROLLMENT MAY BE SUBJECT TO CERTAIN RESTRICTIONS OR REQUIREMENTS AS DEFINED BY THE PLAN.

IS YOUR SPOUSE EMPLOYED? CHECK: YES ☐ NO ☐
NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER

**ARE YOU, YOUR SPOUSE OR DEPENDENTS COVERED UNDER ANY OTHER DENTAL PLAN? IF YES, WHO IS COVERED, PLAN NAME, NAME & ADDRESS OF INSURANCE CO., EFFECTIVE DATE OF COVERAGE** CHECK: YES ☐ NO ☐

| LIST OF DEPENDENTS: FIRST NAME | MI | (IF DIFFERENT) LAST NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH | SEX M/F | RELATIONSHIP (SEE KEY ON BACK) | CIRCLE Y OR N FOR THESE QUESTIONS: DEPENDENT RESIDES WITH YOU? | YOUR IRS DEPENDENT? | ARE YOU FINANCIALLY RESPONSIBLE? |
|---|---|---|---|---|---|---|---|---|---|
| DEP. #1 | | | | | | SPOUSE | | | |
| DEP. #2 | | | | | | | Y N | Y N | Y N |
| DEP. #3 | | | | | | | Y N | Y N | Y N |
| DEP. #4 | | | | | | | Y N | Y N | Y N |
| DEP. #5 | | | | | | | Y N | Y N | Y N |

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS FRAUD WHICH IS A CRIME.

**I HEREBY CONSENT AND AUTHORIZE ANY DENTIST, PHYSICIAN, SUPPLIER, HOSPITAL, PHARMACY, INSURANCE COMPANY, EMPLOYER OR ORGANIZATION TO DISCLOSE ANY INFORMATION REGARDING THE MEDICAL RECORDS CONCERNING MYSELF OR A MEMBER OF MY FAMILY TO CoreSource, Inc. FOR THE PURPOSE OF SUPERVISING AND MONITORING THE HEALTH PLAN(S). THIS CONSENT SHALL BE VALID UNTIL REVOKED IN WRITING BY THE EMPLOYEE.**

EMPLOYEE SIGNATURE _____ DATE _____

**TO BE COMPLETED BY EMPLOYER**

EFFECTIVE DATE _____
☐ NEW ENROLLMENT ☐ RE-ENROLLMENT ☐ NAME CHANGE - FORMERLY: _____
☐ REINSTATEMENT ☐ OPEN ENROLLMENT ☐ CHANGE DEPENDENT STATUS:
☐ CANCELLATION ☐ ADDRESS CHANGE REASON: _____
DATE CHANGE OCCURRED: _____



WHITE TO CoreSource, Inc. • RETAIN YELLOW COPY