INTERACTIVE MEDICAL SYSTEMS DENTAL ENROLLMENT/CHANGE FORM

Please fax to Eligibility Dept. 919-562-0021

Company Name: Group #:

Name of Employee: Last Name, First, Middle

Address: (Street) (City) (State) (Zip Code) (County)

Date Employed:	Is this Member a Late Enrollee? NO ☐ YES ☐	Effective Date of Coverage:

Social Security Number	Date of Birth MM/DD/YY	Sex	Marital Status
__ __ __ / __ __ / __ __ __ __	__ __ /__ __ / __ __	☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

TYPE OF NOTICE

_____ New Enrollment _____ Reissue Card _____ Change/ Correction _____ Termination

EFFECTIVE DATE OF CHANGE/CORRECTION/TERMINATION: ____________________

For Termination, indicate COBRA Qualifying Event:

_____Termination of Employment _____ Death _____ Reduction of hrs _____ Medicare
_____ Loss of Dependent Status _____ Divorce/Separation _____ Other ________________________

Name Change From:____ __________To:__________________________________

Change Address To:____

TYPE OF COVERAGE

☐Employee Only ☐Employee & Spouse ☐Employee & Child(ren) ☐Family

If Dependent Coverage is elected above, please complete the following:

Add or Delete	Name of Dependents	Sex	Birth Date	Social Security Number	Name of School if child is 19 or older
	Spouse:				
	Children:				

Is Spouse Employed Full-Time?
Yes _____ No _____ If yes, complete information below:
Company ____
Company Address ____

Is Employee or Dependents covered for Dental Benefits under another Plan?
Yes _____ No _____ If yes, complete information below:
Company:____
Policy Number:____

I understand employees may change their election and drop dependents during the plan year only if a qualifying change in family status occurs OR at annual enrollment. I authorize any necessary deductions from my salary for any contribution period on a pre-tax basis. I agree the copy of my signature or copy of this form may be accepted as my signature. I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of my coverage. Any benefits applied for shall be effective according to the terms of the Plan Document of the group health plan.

Signature of Employee X	Date Signed

DECLINATION OF DENTAL COVERAGE

I wish to waive Dental Coverage. **I certify that I have been given the opportunity to apply for coverage for which I may have been eligible. I understand the benefits available under the plan and I DECLINE all or dependent coverage because ________________________________.** I wish to waive certain eligible dependents because of other group coverage, their names are: ________________________________. I understand that I and my dependents will not be able to enroll until the next open enrollment.

Signature of Employee: ____ Date: _______________