The Business Council INSURANCE FUND

Group No._____

Dental Enrollment Form (or waiver)

Social Security #			Employer:							
Employee Name: (Last, First, Middle)			Date of Birth			Gender	Date of Hire			
			Month	Day	Year	☐M ☐F	Month	Day	Year	
Employee Mailing Address Zip Code										

If enrolling for coverage, please complete this section

I am enrolling for dental coverage as indicated:

Employee Only Employee plus one Family

Employee Statement - Enrolling for Coverage

I understand that on the effectve date of my insurance coverage, I must meet each of the following conditions: (a) I must be actively at work and able to perform all duties of my occupation; (b) I must be regularly working on a full-time basis at my employer's business establishment or at some other location to which my employer's business requires me to travel, and (c) I have completed any applicable waiting period

I certify that I meet each of the above conditions and understand that I will not be covered otherwise. I authorize my employer to make deductions from my earnings, if contributions are required. I further understand that if I do not make the required written application within thirty-one (31) days of my eligibility date, the group dental benefits will be subject to a one-year waiting period which begins on the date I make written application.

_____ Certified _____

Employee Signature Date Employer Representative Date

Dependent Dental Insurance

Effective	Name of Eligible Dependents to be Covered	Date of Birth	Relationship

If waiving coverage, please complete this section

I decline to enroll for dental insurance for the reason(s) indicated. Please check appropriate box(es)

Coverage Elsewhere Coverage Declined

Employee Statement - Waiving Coverage

I hereby certify that I have been given an opportunity to request group dental coverage available to me and my dependents through my employer. I further understand that if I desire to participate in the Plan and do not make any required written application within thirty-one (31) days of my eligibility date, the group dental benefits will be subject to a one-year waiting period which begins on the date I make written application.

_____ Certified _____

Employee Signature Date Employer Representative Date