enrollment/change/waiver group insurance form

COBRA: If individual is a continuee: Qualifying event _____ Date of event _____

Standard Insurance Company
P.O. Box 82622 / Lincoln, NE 68501-2622
877-490-9991 / Fax: 402-467-7338

Policy and Div. # 160- 754938 Cert. #_____

Name and Address of Employer (Policyholder) **S.E. Scher Corporation DBA Acrobat Outsourcing 665 3rd Street #415, San Francisco, CA 94107**

1 to enroll ☒ Dental ☐ To terminate all coverages

employee information Marital Status ☒ Single ☐ Married

Social Security number **562-23-2813** Dept. number _____

Employee's last name, first name, MI **Allen, Melanie R**

Date of birth **6/30/1961** ☐ Male ☒ Female

Full time date of hire **1/1/2016** ☐ Rehire: Rehire date _____

Occupation **Cook**

Hours worked each week **40** Are your earnings paid: ☒ Hourly or ☐ Salaried

Street address **5545 East 17th Street** City **Oakland** State **CA** ZIP **94621**

E-mail address (limit of 60 characters) **melanie.allen@me.com**

Are you covered under another dental insurance plan?..... **Employee:** ☐ Yes ☒ No **Dependents:** ☐ Yes ☒ No

dependent coverage information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

print full legal name (last, first. MI)	add	drop	relationship	sex	date of birth	social security number
1						
2						
3						
4						
5						
6						

please sign (employee/policyholder) **The certificate provides dental benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X Melanie R. Allen
Employee Signature (do not print) **Date**

X
Policyholder Signature (do not print) **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____

Dependent late entrant date _____

Effective Date	Class	Dep. Code
5/1/2018	**Stripe**	

2 to change

☐ **Name change** New Name _____ Old Name _____

☐ **Add dependent coverage**

- ☐ If due to marriage, what is the date of marriage? _____
- ☐ If due to birth/adoption, what is the date of event? _____
- ☐ If due to loss of coverage, date and reason: _____
- ☐ If other, the date of event and please explain: _____

☐ **Drop dependent coverage** Number of dependents still covered: _____ Effective date of drop: _____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse only** ☐ **child(ren) only** ☐ **spouse and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

USAvision & dental

New Membership Enrollment Form

Member's SSN

5	6	2	2	3	2	8	1	3

All fields marked "*" are required. Complete clearly in **Blue** or **Black** ink only. FAX this form to: **888.959.4393**, securley email it to: **GroupSupport@USAvision.net**, or mail it to: **Membership Enrollment, USAvision, Inc., 3851 E Tuxedo Blvd. Suite C, Bartlesville OK 74006.** Failure to complete this form correctly may result in delayed enrollment and/or a later Coverage Start Date.

Section A: Coverage Selection

Your Employer*: S. E. Scher Corporation DBA Acr

Coverage Start Date*: 05/01/2018

Coverage Level* **(check all that apply)**: Member (X) Spouse ( ) Child(ren) ( )

Section B: Member

Name*: Melanie Allen

Date of Birth*: 06/30/1961 Gender*: F Phone: 510-326-6552

Mailing Address*: 5545 East 17th Street

City, State & ZIP Code*: Oakland, CA 94621

Section C: Spouse & Dependent Children **(More than 4 children? Attach another copy of this form)**

Spouse's Name

Date of Birth MM/DD/CCYY Gender SSN - -

Child #1 Name

Date of Birth MM/DD/CCYY Gender SSN - -

Child #2 Name

Date of Birth MM/DD/CCYY Gender SSN - -

Child #3 Name

Date of Birth MM/DD/CCYY Gender SSN - -

Child #4 Name

Date of Birth MM/DD/CCYY Gender SSN - -

Section D: Your Acknowledgement & Signature

I hereby request coverage as outlined above under USAvision and VSP for the Vision group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the policy provisions. I declare all answers are true and complete. **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signature: Melanie R. Allen

Today's Date: 04/25/2018

| Melanie Allen | EaseCentral