



LifeMap Assurance Company™
 P.O. Box 1271 E-3A
 Portland, OR 97207-1271

Please return forms to:
 EPK & Associates, Inc.
 15375 SE 30th Pl, # 380
 Bellevue, WA 98007

**Group Voluntary Dental Insurance
 Employee Enrollment and Change Form**

Employee ID Number
Employee Class

Please complete all information on this page and on page 2.

Employer Name		Group Number		
<input type="checkbox"/> New Enrollment – Date of Hire (mm/dd/yyyy) _____ Date of Rehire (mm/dd/yyyy) _____ Date of Full-Time (Benefit Eligible) Employment (mm/dd/yyyy) _____ (part time employment will count towards waiting period)		<input type="checkbox"/> Change of Existing Enrollment		
Employee's Last Name	Employee's First Name	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
Social Security Number	<input type="checkbox"/> Married / Domestic Partner (Spouse) <input type="checkbox"/> Divorced <input type="checkbox"/> Single		Telephone Number ()	
Home Address & Apt. No./Mailing Address	City	State	Zip	Requested Effective Date

Dependents to be enrolled: Dependent children must be unmarried and under 26 years of age.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship (Spouse, Child)
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

If changing existing enrollment, indicate reason below:

<input type="checkbox"/> Name Change – Former name _____	<input type="checkbox"/> Address Change
<input type="checkbox"/> Add Dependent(s) due to: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage / Domestic Partnership – Date _____	
<input type="checkbox"/> Newborn - Date of Birth _____	<input type="checkbox"/> Adoption - Date of Placement in Home _____
<input type="checkbox"/> Loss of Coverage - Date _____	Reason _____
Name of Prior Carrier _____	Telephone Number _____
Prior Policy Number _____	Identification Number _____
Coverage was <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Coverage was for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family as listed above (check all that apply)	



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Other Coverage Information

This is not a waiver of coverage. This information is required for payment of claims.

Do you or any family members enrolling have other dental coverage? Yes No

If yes, provide the information regarding other coverage requested below.

Name of Family Member with other coverage		Relationship
Name of Insurance Carrier		Carrier Phone No. ()
Address of Other Carrier	City	State Zip
Policy Number _____	ID Number _____	Effective Date of Coverage
This plan covers <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family as listed above <input type="checkbox"/> Other _____ (check all that apply)		Termination Date (if applicable)
Is the coverage of any dependent affected by a divorce decree/court order? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include portion of decree that shows responsibility for health expenses.		

I hereby apply for enrollment with under LifeMap Assurance Company the Group Dental Insurance Policy of the Employer named on Page 1. I hereby authorize the Employer named on Page 1 to withhold insurance premiums, if required, from my paycheck and to pay them to LifeMap Assurance Company.

I acknowledge and understand LifeMap Assurance Company may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statement, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

INSURANCE FRAUD WARNING: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all coverage under this Policy will terminate for such Member retroactively to the Effective Date.

▶ _____
 Employee's Full Name (please print clearly)

▶ _____
 Employee's Signature

▶ _____
 Date Signed