## **Employee Application for Group Dental Insurance**

## Florida Combined Life

FCL Group No.	Group No. 1 Group Name									2 Bus	Business Phone No. 3				
Division No.	4 Class					5					Effective Date MM DD YY			6	
SECTION 2: To be completed										-					
Part A: Complete the following	• •														
					Secu	ecurity No. 8					date		MM DD YYYY	9	
Street Address						11	Cour			12 Sta	ate	13	Zip Code	14	
Home Phone No. 15 Busine	ss Phon	ne No.	. 16	Occupation	n/Jok	o Title						tatus		19	
						□M □F					☐Single ☐Divorced ☐Legally ☐Married ☐ Widowed Separated				
Full-time MM DD YYYY 20 Hire date / /	- 7		at wo	ork □Retire	d □	COBR	<b>21</b> A		w Paid Hourly	d? ⊂⊟Sala	<b>22</b> y	Hours	s worked per week	23	
Part B: Coverage Selection (			-	•								-	•		
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☐Yes ☐No, I decline ☐Yes ☐No, I decline coverage						☐Yes ☐No, I <b>decline</b> enrolled.									
If you checked YES in the Em  ☐BlueDental Freedom (Inde	ployee (	Covera	age s	selection box		lect one	e of th	nese	plans					27	
☐BlueDental Care (Prepaid	)								•	•	ıt	[	□Plus		
Part C: Identify each individu Attach additional sheet of p										Cho	ck If				
and date it.			0.4					0.5	00						
First Name, M.I., Last Name		30	31	32		33	34	35	36	37	38	39		40	
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FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

## **Acceptance of Coverage**

## Please Read Before Signing the Front Side of this Form

I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. if my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any COBRA or ERISA rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If coordination of benefits applies for me and my dependents and an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL coverage later, coverage will not be available until the next open enrollment.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application, labeled "White copy – FCL," is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.