FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.

5011 GATE PARKWAY, BLDG. 200
JACKSONVILLE, FLORIDA 32256

EMPLOYEE APPLICATION FOR GROUP DENTAL INSURANCE

SECTION 1: TO BE COMPLETED BY GROUP INSURANCE ADMINISTRATOR OR EMPLOYER

FCL Group No.: _____ Group Name: Alachua County _____ Business Phone #:(____) _____

Division No.: _____ Class: _____ Effective Date: Mo. | Day | Yr. |

SECTION 2: TO BE COMPLETED BY EMPLOYEE (Please print.)

Part A: Complete the following part with information on **yourself**.

Full legal name of employee: (Last, First, MI)		Social Security #:		Birthdate: Mo. Day Yr.
Street Address:		City: County:		State: Zip Code:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	Sex: ☐ M ☐ F	Home Phone #: ( )	Business Phone #: ( )	Occupation/Job Title:
Full-time hire date: Mo. Day Yr.	Are you: ☐ Actively at work ☐ Retired ☐ COBRA	How paid? ☐ Hourly ☐ Salary		Hours worked per week:

Part B: Coverage Selection *(Note: Consult your group insurance administrator for benefits available to you.)*

Employee: ☐ Yes ☐ No, I **decline** coverage. (*If **yes**, select one of the Plans below.*)

☐ BlueDental Choice (PPO) (check one, as applicable) ☐ High or ☐ Low ☐ BlueDental Care (Prepaid) _____

☐ BlueDental Freedom (Indemnity) _____

(Dependents cannot be enrolled for coverages declined by the employee)

Spouse: ☐ Yes ☐ No, I **decline** coverage. **Child(ren):** ☐ Yes ☐ No, I **decline** coverage. *(If selected, all children must be enrolled.)*

Part C: Identify each individual to be covered below. **Attach additional sheet of paper, if necessary. Sign and date it.**

Name (Last, First, MI)	Social Security Number	Birthdate Mo. Day Yr.	CHECK IF Sex	Supported by You	Living with You	Full-time/ Part-time Student	Disabled	BlueDental Care PREPAID ONLY Dental Facility No.	Current Patient Yes	No
Employee	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Spouse			☐ M ☐ F	N/A	N/A	N/A	N/A			
Child			☐ M ☐ F							
Child			☐ M ☐ F							
Child			☐ M ☐ F							

Do any dependents listed above reside at a different address than indicated above? ☐ Yes ☐ No. If "Yes" list name(s): _____

Do you or any of your dependents have other Dental insurance under a group plan? ☐ Yes ☐ No. Is the other plan a DHMO or Prepaid plan? ☐ Yes ☐ No. If you answered "Yes" to other group dental insurance, complete the following:

Dependent Name	Other Group Plan Name & Plan No.	Policy #	Insurance Co. Name and Address	Insured/Member Name	Member DOB

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.

Part D: COVERAGE ACCEPTANCE (Read before signing.)

I wish to apply for any coverage checked **Yes** under Part B – Coverage Selection. I have read and accept the "Acceptance of Coverage" on the reverse side of this form. I hereby certify that the statements on this application, including any attachment to it, are true and complete. (If you checked NO for any dependent under Part B, sign and date part E also.)

Employee Signature:_____ Date:_____

Part E: COVERAGE REFUSAL (Read before signing.)

I do **not** wish to apply for any coverage checked **No** under Part B – Coverage Selection. I understand that, if I decide to apply at a later time, coverage will not be available until the next open enrollment.

Employee Signature:_____ Date:_____

ACCEPTANCE OF COVERAGE
(READ BEFORE SIGNING ON THE FRONT 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 Employee Retirement Income Security Act (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.