



dental health
OPTIONS™

SUBSCRIBER ENROLLMENT APPLICATION

New Employee Open Enrollment Change of Status (see below)

Reason for Change of Status: Marriage Divorce Death Other _____

HRI to complete	
Group No.	Plan No.
Effective Date	Term of Contract

PLEASE PRINT CLEARLY AND COMPLETELY

1. Name _____
Last First Init. Social Security No.

Street _____ Date of Birth _____

City State Zip Phone _____

Male _____ Female _____ Single _____ Married _____ Email address _____

2. Employer _____ Position _____ Hire Date _____

3. I elect dental coverage for _____ Myself _____ Spouse _____ One Child _____ Children No. of insureds
I decline coverage for _____ Myself _____ Spouse _____ One Child _____ Children

4. Spouse and Children Information: (Complete for all COVERED dependents.)

NAME	RELATIONSHIP	BIRTHDATE	M/F	SOC. SEC. #	College Disabled/Student	Covered by other dental policies
2. _____	Spouse	/ /		- -	/	
3. _____		/ /		- -	/	
4. _____		/ /		- -	/	
5. _____		/ /		- -	/	
6. _____		/ /		- -	/	

Because HRI observes the "birthday rule" in coordinating children's dental benefits, provide the birth date of the parent who provides other dental coverage _____. Attach full-time student status proof if you are electing coverage for dependents over age 19. HRI needs updates each semester.

5. Dentist(s): (Optional) _____

6. I understand that I may not change my coverage until next open enrollment period. I may not change coverage on my dependents until next open enrollment period unless I have a change in my family status.

7. Signature, Release, and Assignment:

If coverage is approved and issued, I authorize Health Resources, Inc., (Dental Health Options), to make payment of any benefits directly to the dentist as the supplier of services rendered. I understand that the dentist(s) I have chosen to use are independent contractors, and are not employees of HRI. I authorize the dentist to release to Health Resources, Inc. any information regarding my history, symptoms, treatment, examination results or diagnosis. I further authorize HRI and the dentists providing services to transmit by any means any and all information regarding services performed for me and my dependents enrolled under this plan as may be required for the payment or evaluation of claims. A photocopy of this authorization shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this authorization. The information given is correct and true.

Date _____ Signature of employee _____

If this application is accepted, the information herein is an integral part of the plan. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For Central/Southern IN & KY Customers,
Mail or Fax to:
P.O. BOX 15660
EVANSVILLE, IN 47716-0660
(812) 424-1444
(800) 727-1444
(812) 424-2096 FAX
(SUBS ENR AP 03/06)

Forms distribution: White - HRI, Yellow - Employer, Pink - Agent



www.HRI-DHO.com

For Northern IN Customers,
Mail or Fax to:
P.O. BOX 2845
ELKHART, IN 46515-2845
(574) 206-8844
888-455-5141
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