CITY OF VENICE
Group Dental Insurance Enrollment/Change Form

Section 1: Personal Information

Employee/Retiree Name (Last, First, MI)	Social Security No.	Birthdate		Gender ☐ M ☐ F
Home Street Address	City	State	Zip Code	Telephone No.

Section 2: New Enrollment

☐ **ADD**	Coverage Level: ☐ Individual Only ☐ Individual + 1 ☐ Family	Plan: ☐ Core Plan (Plan B) ☐ Plus Plan (Plan A)	Effective Date:

Section 3: Change

☐ **CHANGE COVERAGE to** *Must complete Section 4 below* ☐ Individual Only ☐ Individual + 1 ☐ Family	☐ **CHANGE PLAN to** ☐ Core Plan (Plan B) ☐ Plus Plan (Plan A)	Effective Date:
☐ **DROP ALL DENTAL COVERAGE**	☐ **DROP DEPENDENT** *Complete Section 4*	☐ **ADD DEPENDENT** *Complete Section 4*

Section 4: Dependent Information (Attach additional sheet of paper, if necessary. Sign and date it.)

☐ **ADD** ☐ **DROP**	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender ☐ M ☐ F	Relationship SPOUSE
☐ **ADD** ☐ **DROP**	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender ☐ M ☐ F	Relationship CHILD
☐ **ADD** ☐ **DROP**	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender ☐ M ☐ F	Relationship CHILD
☐ **ADD** ☐ **DROP**	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender ☐ M ☐ F	Relationship CHILD
☐ **ADD** ☐ **DROP**	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender ☐ M ☐ F	Relationship CHILD
☐ **ADD** ☐ **DROP**	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender ☐ M ☐ F	Relationship CHILD

Section 5: Other Coverage (Attach additional sheet of paper, if necessary, Sign and date it.)

Do any dependents listed above have Dental insurance under another group plan? ☐ YES ☐ NO
If **yes** for each dependent with other coverage, please provide:

Name of Dependent with Other Coverage	Group Plan Name & No.	Insured Member Name	Insured Member Birthdate
Name of Dependent with Other Coverage	Group Plan Name & No.	Insured Member Name	Insured Member Birthdate
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Section 6: Acceptance/Declination of Coverage

☐ I wish to apply for coverage as indicated above. 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.

☐ **Employee:** I do not wish to apply for any coverage. I understand that if I decide to apply at a later time, coverage may not be available until the next open enrollment.

☐ **Retiree:** I understand that if I drop coverage, I will **NOT** be eligible to apply again.

Section 7: Signature

Employee/Retiree Signature	Date

8/22/2012

Acceptance of Coverage

Please Read Before Signing the Front Side of this Form

I hereby apply for the coverage indicated on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance, 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.

I agree to be bound by the group contract's terms and conditions.