

# Enrollment/Change or Waiver Form for Dental and Vision Coverage

**Employer/Policyholder: Trustees of Hamilton College**  
**Policy Numbers: 201361 (dental) / 12251453 (vision)**

Employer Use Only:  
 Effective Date \_\_\_\_\_  
 1<sup>st</sup> Deduction Date \_\_\_\_\_

Employee's Name \_\_\_\_\_ Dept. \_\_\_\_\_

Complete Address \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Date of Hire \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status:  Single  Married

**► To Enroll** (please check one):

- New Hire
- New Enrollment
- Life change event (please check one)
  - Marriage  Divorce  Birth/Adoption of Child  Loss of coverage

**► Type of Coverage Desired:**

- Dental with First Ameritas
- Vision with VSP

• Date of Life Event \_\_\_\_\_

I would like to enroll the following dependents in: <input type="checkbox"/> Dental with First Ameritas <input type="checkbox"/> Vision with VSP				
Full Name	Soc. Sec. #	Relationship	Date of Birth	Sex

**► To Change:**

- Add  Dental  Vision **Dependent Coverage** (complete dependent information above)
- Drop  Dental  Vision **Dependent Coverage** (name of dependents:) \_\_\_\_\_
- Cancel  Dental  Vision **Coverage for me and all of my dependents.**

**► To Waive Coverage** (If you do not want coverage, complete this section):

- I have been given an opportunity to apply for group insurance offered by my employer, and have decided not to accept the offer. Should I desire to apply for dental in the future, I realize that a "late entrant" penalty may be applied.

Reason for Waiver \_\_\_\_\_

**► Please Sign:** As an employee, I hereby apply for, or waive (if indicated) group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. **The following applies to section 125 flexible benefits plans:** I am signing up for coverage until the next enrollment period except in the case of a change in family status. This information was explained in the plan's solicitation materials which I have read and understand. I certify that the information I have provided is complete and accurate.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Any person who knowingly and with intent to defraud any insurance company or other reason files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.