CORESOURCE
A Trustmark Company

GROUP DENTAL BENEFIT PLAN ENROLLMENT FORM

PLEASE PRINT

EMPLOYER	OCCUPATION	DEPT	LOCATION	DATE EMPLOYED / /

SOCIAL SECURITY #	LAST NAME	FIRST	MI	SEX ☐ M ☐ F	BIRTH DATE / /	EMPLOYEE PHONE # ( )

EMPLOYEE'S HOME ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP)

MARITAL STATUS: (CHECK APPROPRIATE BOX(S) AND FURNISH DATE) ☐ NEVER MARRIED ☐ MARRIED ___/___/___ ☐ WIDOWED ___/___/___
☐ LEGAL SEPARATION ___/___/___ ☐ DIVORCED* ___/___/___ ☐ REMARRIAGE ___/___/___

* IF EVER DIVORCED AND ENROLLING DEPENDENTS, PLEASE PROVIDE A COPY OF THE PORTION OF ANY DIVORCE DECREE(S) REFERRING TO CUSTODY AND RESPONSIBILITY FOR HEALTH EXPENSES OF ANY DEPENDENTS DIRECTLY TO CoreSource, Inc. BE SURE TO INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND EMPLOYER NAME WITH THE DECREE. ELIGIBILITY FOR YOUR DEPENDENTS CANNOT BE DETERMINED AND CLAIMS WILL NOT BE CONSIDERED FOR PAYMENT UNTIL YOU HAVE RETURNED THE REQUESTED INFORMATION.

TYPE OF COVERAGE: (CHECK ONE) ☐ INDIVIDUAL (EMPLOYEE ONLY) ☐ EMPLOYEE PLUS ONE ☐ EMPLOYEE PLUS TWO
☐ FAMILY (EMPLOYEE & ELIGIBLE DEPENDENTS) ☐ NO COVERAGE

☐ IF NO COVERAGE HAS BEEN SELECTED, I HEREBY REFUSE THE BENEFIT PLAN OFFERED BY MY EMPLOYER AND UNDERSTAND THAT MY FUTURE ENROLLMENT MAY BE SUBJECT TO CERTAIN RESTRICTIONS OR REQUIREMENTS AS DEFINED BY THE PLAN.

IS YOUR SPOUSE EMPLOYED? CHECK: YES ☐ NO ☐
NAME, ADDRESS AND PHONE #
OF SPOUSE'S EMPLOYER

ARE YOU, YOUR SPOUSE OR DEPENDENTS COVERED UNDER ANY OTHER DENTAL PLAN? CHECK: YES ☐ NO ☐
IF YES, WHO IS COVERED, PLAN NAME, NAME & ADDRESS OF INSURANCE CO., EFFECTIVE DATE OF COVERAGE

LIST OF DEPENDENTS: FIRST NAME	MI	(IF DIFFERENT) LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M/F	RELATIONSHIP (SEE KEY ON BACK)	CIRCLE Y OR N FOR THESE QUESTIONS: DEPENDENT RESIDES WITH YOU?	YOUR IRS DEPENDENT?	ARE YOU FINANCIALLY RESPONSIBLE?
DEP. #1						SPOUSE			
DEP. #2							Y N	Y N	Y N
DEP. #3							Y N	Y N	Y N
DEP. #4							Y N	Y N	Y N
DEP. #5							Y N	Y N	Y N

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS FRAUD WHICH IS A CRIME.

I HEREBY CONSENT AND AUTHORIZE ANY DENTIST, PHYSICIAN, SUPPLIER, HOSPITAL, PHARMACY, INSURANCE COMPANY, EMPLOYER OR ORGANIZATION TO DISCLOSE ANY INFORMATION REGARDING THE MEDICAL RECORDS CONCERNING MYSELF OR A MEMBER OF MY FAMILY TO CoreSource, Inc. FOR THE PURPOSE OF SUPERVISING AND MONITORING THE HEALTH PLAN(S). THIS CONSENT SHALL BE VALID UNTIL REVOKED IN WRITING BY THE EMPLOYEE.

EMPLOYEE SIGNATURE ______________ DATE ______

TO BE COMPLETED BY EMPLOYER

EFFECTIVE DATE ________
☐ NEW ENROLLMENT ☐ REINSTATEMENT ☐ CANCELLATION
☐ RE-ENROLLMENT ☐ OPEN ENROLLMENT ☐ ADDRESS CHANGE
☐ NAME CHANGE - FORMERLY: ________
☐ CHANGE DEPENDENT STATUS:
REASON: ________
DATE CHANGE OCCURRED: ________

DEPENDENT RELATIONSHIP CODE KEY

RELATIONSHIP CODES

N = Natural child
Adopted child - *If applicable, please submit copies of divorce decree directly to CoreSource, Inc., identifying health coverage for dependents.*

S = Student - Children over age 18 or graduated from high school continuing higher education. Must attend 12 credit hours per semester/quarter to be considered a full time student. If applicable, as defined in the employers plan, please submit verification of full time status along with your completed enrollment. Any of the following records would be satisfactory:

- Grade reports
- Transcripts
- Copy of school registration
- Cancelled checks from registration

H = Handicapped - Please obtain a Certificate of Disability for Handicapped Children from your employer. Complete the form and return to our office with your completed enrollment form.

T = Stepchild - Please submit copies of divorce decree directly to CoreSource, Inc., identifying medical coverage for dependents.

O = Others - Please submit copies of the legal document.

If the child or children are adopted, handicapped or a relationship of other, we need additional documentation in order to determine eligibility. Please note all information will be held in confidence.

All dependents are subject to the terms and conditions of your plan. Not all dependents are eligible.

EXAMPLE:

LIST OF DEPENDENTS: FIRST NAME MI (IF DIFFERENT) LAST NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M/F	RELATIONSHIP (SEE KEY ON BACK)		CIRCLE Y OR N FOR THESE QUESTIONS: DEPENDENT RESIDES WITH YOU?	YOUR IRS DEPENDENT?	ARE YOU FINANCIALLY RESPONSIBLE?
DEP. #1	Mary E.	123-45-0045	5-1-45	F	SPOUSE				
DEP. #2	David A.	789-23-1234	9-30-72	M	Son	S	(Y) N	(Y) N	(Y) N
DEP. #3	Sara S.	634-28-0022	5-6-85	F	Daughter	N	Y (N)	(Y) N	(Y) N
DEP. #4	Todd R. Dean	890-00-8300	3-17-74	M	Stepson	T	(Y) N	Y (N)	(Y) N
DEP. #5	Barry M. Doe	173-89-0070	10-2-83	M	Grandson	O	(Y) N	(Y) N	(Y) N

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Daniel J. Jones
EMPLOYEE SIGNATURE

8-10-92
DATE

SUBMIT DOCUMENTATION TO: CoreSource, Inc., 5200 Upper Metro Place, Suite 300, Dublin, OH 43017-5378