

**Provident Life and Casualty
Insurance Company**



Dental and Vision Enrollment Form
 Provident Life and Casualty Insurance Company
 1 Fountain Square, Chattanooga, TN 37402
 Fax Number: 207-771-4019

Please print legibly and complete this form in its entirety. Blank fields will cause delays in processing.

- Initial Enrollment: To make initial elections; or
- Annual Enrollment or Change in Status: To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file. Note: If you do not wish to make any changes, do not complete this form. Please contact your employer with any questions.
- Terminate Coverage: To terminate coverage for yourself and all dependents.
- Waive coverage. Covered under Spouse's group plan I have other coverage Other: _____

Employer Name		Policy No.	Division No.	Effective Date
Employee Social-Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	Hours Worked Per Week	
Employee First Name	M.I.	Last Name		
Employee Street Address		City	State	Zip Code
Original Date of Hire	Actively Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date entered into an eligible class (ex: part time to full time or promotion date) <input type="checkbox"/> Rehire date _____		

SPOUSE/DEPENDENT ELECTIONS: (For additional dependents, complete and attach an additional form.)

Name (First, MI, Last)	Gender	Date of Birth	Relationship	Election (A=Add; T=Terminate)	Effective Date (if different)
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> A <input type="checkbox"/> T	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> A <input type="checkbox"/> T	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> A <input type="checkbox"/> T	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> A <input type="checkbox"/> T	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> A <input type="checkbox"/> T	

If dependent children listed are disabled or full-time students age 19 or over, please contact your group administrator.

COVERAGE ELECTIONS:

Type of Coverage	Employee Only	Employee/Spouse	Employee/Child(ren)	Employee/Family
Dental <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Other <input type="checkbox"/> Waive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Other <input type="checkbox"/> Waive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REPLACEMENT:

In the past 12 months, have you had continuous coverage providing like or similar benefits with a prior carrier?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide:	Policyholder:	Insurance Company:	

The certificate provides limited benefits. Review your certificate carefully.

Request for Signature and Certification: I understand that my coverage may be subject to waiting periods, limitations, exclusions and termination as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer and will not be effective until approved. All statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I understand that any untrue statement or material misrepresentation may result in claim denial or cancellation of coverage. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

I understand that if I waive coverage and later decide to enroll, late entrant penalties may apply.

Any person who knowingly and with intent to defraud any insurance company or other person 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.

Employee Signature Date (mm/dd/yyyy)

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

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