

Self Skilled Nursing Home LLC
Direct Reimbursement Dental Benefits Plan

Enrollment Form

Coverage Selected:

Single: ☐

\$14.46 pp

Emp +1 ☐

\$27.11 pp

Family ☐

\$31.67 pp

E-mail: (required) _____

Email required to receive dental claim
EOB. Please print clearly

New Employee: ☐

Status Change: ☐

Termination: ☐

Name: Last, First, MI _____

Address: _____ City: _____ St: _____ Zip: _____

Social Security # _____

Date of Birth: _____ Male: ☐ Female: ☐ Date of Hire: _____
mm/dd/yyyy

Effective Date of Coverage: _____ Date Of Termination: _____
mm/dd/yyyy mm/dd/yyyy

Complete the following section if you wish to cover dependents

Married? ☐ Date of Marriage: _____ Dependent Children? ☐

Are you, your spouse or dependent children covered under another dental plan?

If yes, who is covered? _____

Name of insurance carrier for other coverage and policy # _____

Enroll your spouse and dependent children below

Last Name	First Name	SS#	Relationship	Date of Birth

Dependents eligible for coverage under this plan are defined as:

- Legal spouse of covered employee
- Unmarried children to age 19 provided such children are dependent upon the employee for support and maintenance. College age children shall be covered provided they are full-time students.
- Children of a covered employee who have attained the age specified in the previous paragraph who are incapable of self-sustained employment due to a handicap or disability and who are still dependent on the employee.

Signature: _____ Date: _____

Employer Signature: _____ Date: _____

☐ I elect not to participate in the Arbor Springs Direct Reimbursement Dental Plan and understand that I may not enroll myself or dependents until the next open enrollment period.

Employee Signature: _____ Date: _____