Dearborn National

Underwritten by Dearborn National® Life Insurance Company

Enrollment and Change Form

Administrative Offices: Downers Grove, Illinois I Dallas, Texas

☐ New Enrollment ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Retiree

Employer/Employee Section

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self-administered, submit enrollment forms to Dearborn National only if evidence of insurability is required.

EMPLOYER	GROUP NO. / ACCOUNT NUMBER	LOCATION
HERSCHER COMMUNITY UNIT SCHOOL DISTRICT	F1D1432	

EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	GENDER ☐ M ☐ F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)

SOCIAL SECURITY NO.	EARNINGS Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐	JOB TITLE	CLASS

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

BENEFIT SELECTION - DENTAL

ENROLLMENT

Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

(Choose One)

☐ Employee
☐ Employee +1
☐ Family

Plan Choice:

☐ High
☐ Low

POLICY CHANGE

(Check Reason for Change)

☐ Married
☐ Birth / Adoption
☐ Widowed
☐ Divorced
☐ Address Change

CANCEL COVERAGE

☐ Terminate Coverage
Date / /
☐ Leave / Layoff
☐ Other
Date / /

If above selection covers your spouse, is your spouse covered under any other dental plan? ☐ Yes ☐ No If Yes, carrier's name:

COBRA CONTINUATION PRIVILEGE

Start Date: / /

Projected End Date: / /

Previously covered with group as:

☐ 1. Employee (termination, reduction in hours, other)
☐ 2. Spouse (divorce from employee, death of employee)
☐ 3. Dependent (reached age limit, married, no longer a Full Time Student, other)
☐ 4. Spouse & Dependents (divorce from employee, death of employee, other)

For the purposes of this Notice, while prohibited by Federal law, Spouse does not include a same-sex Domestic Partner or Party to a Civil Union. Such benefits may be available under state law if provided by the policyholder.

COVERED SPOUSE AND DEPENDENTS

Dependent Child(ren) over the age limit, indicate if Full Time Student (FTS) or Handicapped (HDCP).

First Name	Last Name	Social Security Number	Date of Birth	Relationship	SEX	Adult Child FTS or HDCP	Name of Accredited School
				SPOUSE	☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR DEARBORN NATIONAL USE ONLY

(to Apply)

EMPLOYEE SIGNATURE X

DATE / /

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

(waiver on Pg 2)

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Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE X _____ DATE ___/___/___

EMPLOYER
HERSCHER COMMUNITY UNIT SCHOOL DISTRICT

EMPLOYEE NAME - LAST FIRST

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