SOUTHLAND
BENEFIT SOLUTIONS

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BENEFIT PLAN ENROLLMENT / CHANGE FORM

Part 1

Plans Desired:

Dental Program
- ☐ Traditional / Base Plan
- ☐ Enhanced Plan

Vision Program
- ☐ Superior Vision
- ☐ Vision Choice

Check One:
- ☐ New Subscriber
- ☐ Open Enrollment
- ☐ Add/Delete Dependent
- ☐ Terminate Coverage
- ☐ Other _____

Part 2

Name of Employer / Group:_____ Location: _____

Primary Enrollee Information

Name: _____
First MI Last

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____
Month Day Year

SSN#: _____ - _____ - _____ Marital Status: ☐ Single ☐ Married

Mailing Address: _____ Apt #: _____
Street

City: _____ State: _____ Zip: _____

Phone #: (_____) _____-_____ Membership/Hire Date: _____/_____/_____

Email: _____

Coverage Desired: ☐ Single ☐ Single + Child ☐ Single + Spouse ☐ Family

Do you have dependent children? ☐ Yes ☐ No

Covered Dependent Information (Name)

	Add	Delete	Male	Female	Date of Birth
Spouse _____	☐	☐	☐	☐	____/____/____
Dependent _____ (First MI Last)	☐	☐	☐	☐	____/____/____
Dependent _____ (First MI Last)	☐	☐	☐	☐	____/____/____
Dependent _____ (First MI Last)	☐	☐	☐	☐	____/____/____

Are you or your dependents covered under another dental or vision plan? ☐ Yes ☐ No

If yes, name of other insurer / carrier: _____

Are all listed dependent children under age 26? Yes ☐ No ☐

Part 3

- ☐ I hereby apply for benefits for which I am eligible. I authorize any deduction that may be required towards the cost of this program. I certify that the information in this form is true and correct to the best of my ability. This program does not become effective until approved by Southland Benefit Solutions.
- ☐ I decline the dental program at this time.
- ☐ I decline the vision program at this time.

Insurance Notice: Any person who knowingly and with intent to injure, defraud, or deceive files a statement of claim or an application with any false, incomplete, or misleading information is guilty of insurance fraud.

Signature of Subscriber: _____ Date: _____

AL-SDC-2019

Enrollment Instructions

1. **Part 1:** Select the plan(s) for which you are enrolling in and check the box describing the status of your application.
2. **Part 2:** Fill in all demographic information, being sure to include the names of all dependents you wish to include on your plan.
3. **Part 3:** Check the authorization for deduction box and sign your name at the bottom. Return the completed application to Human Resources or appropriate party.

Completed applications received by Southland Benefit Solutions by the 15th of the month will become effective on the 1st of the following month.

Dental Plan

- ☐ Single $_____
- ☐ Single + Spouse $_____
- ☐ Single + Child(ren) $_____
- ☐ Single + Family $_____
- ☐ Waive

Superior Vision (Insured Plan)

- ☐ Single $_____
- ☐ Single + Spouse $_____
- ☐ Single + Child(ren) $_____
- ☐ Single + Family $_____
- ☐ Waive

Vision Choice (Discount Plan)

- ☐ Single $_____
- ☐ Single + Family $_____
- ☐ Waive

For Southland Use Only:

Date Received: _____
Effective Date: _____
Group No: _____
Account No: _____
Monthly Cost: _____
Plan Code: _____
Date Entered: _____