SIHO INSURANCE SERVICES

417 Washington Street
Columbus, IN 47201
800-443-2980

SIHO Dental and Vision Employee Enrollment Form

Employer Name: _____

Employee Information (Please print clearly)

If your employer offers more than one plan option (available for groups with 50 or more employees) please select your plan:

Dental: ☐ **Preferred** ☐ **Standard** ☐ **Value**

Vision: ☐ **12/12 Plan (V00828)** ☐ **12/24 Plan (V00829)**

I am applying for coverage for:

☐ **Employee Only** ☐ **Employee & Spouse** ☐ **Employee & Child(ren)** ☐ **Employee & Family**

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security #_____ Email Address _____

Home Phone _____ Work Phone _____ Birth Date _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please complete the table below for each person that will be covered.

	Last Name	First Name	Social Security #	Birth Date	Sex F/M	Relation to Employee*
01 Self						
02 Spouse						
03 Child						
04 Child						
05 Child						
06 Child						
07 Child						

* C = natural or adopted child. If child is 19-24 and not on SIHO Health Plan, please provide full-time college verification. *O = stepchildren, other blood relatives, or child subject to legal guardianship. If child is not on SIHO Health Plan, please provide full-time college verification or documentation of financial dependency.

If additional dependent information is necessary, please attach a separate sheet of paper.

Does spouse have a dental plan? ☐ Yes ☐ No If "yes," with whom?_____

Please Sign (employee/policyholder) The certificate provides dental and eye care benefits only. Review your certificate carefully. As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS: I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

_____ _____

Employee Signature Date