HEALTH RESOURCES, INC.
P.O. BOX 15660 • EVANSVILLE, IN 47716-0660
(800) 727-1444 Tel • (812) 424-2096 Fax
www.HRI-DHO.com

SUBSCRIBER ENROLLMENT APPLICATION

dental health OPTIONS™

PLEASE PRINT CLEARLY AND COMPLETELY (Black ink preferred)

❑ New Employee ❑ Open Enrollment ❑ Change of Status (see below)
Reason for Change of Status ❑ Marriage ❑ Divorce ❑ Other _____
Date of change _____ Benefits Administrator's Authorization _____

1. Name _____ _____
Last First Init. Social Security No.

_____ _____
Street Date of Birth

_____ _____
City State Zip Phone

Male ____ Female ____ Single ____ Married ____ Email address _____

2. Employer _____ Phone _____ Hire Date _____ Position _____

3. I elect dental coverage for ____ Myself ____ Spouse ____ One Child ____ Children ☐ No. of insureds
I decline coverage for ____ Myself ____ Spouse ____ One Child ____ Children

4. Spouse and Children Information: (Complete for all COVERED dependents.)

	NAME	RELATIONSHIP	BIRTHDATE	M/F	SOC. SEC. #	College Disabled/Student	Covered by other dental policies?
2.		Spouse	/ /		- -	/	
3.			/ /		- -	/	
4.			/ /		- -	/	
5.			/ /		- -	/	
6.			/ /		- -	/	

Because HRI observes the "birthday rule" in coordinating children's dental benefits, provide the birth date of the parent who provides other dental coverage _____ . Attach full-time student status proof (i.e. school schedule, transcript) if you are electing coverage for dependents over age 19. HRI needs updates each semester. Attach a doctor's statement if dependent child is disabled.

5. Signature, Release, and Assignment:
I understand that I may not change my coverage until next open enrollment period. I may not change coverage on my dependents until next open enrollment period unless I have a change in my family status. If coverage is approved and issued, I authorize Health Resources, Inc., (Dental Health Options), to make payment of any benefits directly to the dentist as the supplier of services rendered. I understand that the dentist(s) I have chosen to use are independent contractors, and are not employees of HRI. I authorize the dentist to release to Health Resources, Inc. any information regarding my history, symptoms, treatment, examination results or diagnosis. I further authorize HRI and the dentists providing services to transmit by any means any and all information regarding services performed for me and my dependents enrolled under this plan as may be required for the payment or evaluation of claims. A photo copy of this authorization shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this authorization. The information given is correct and true.

Date _____ Signature of Employee _____

If this application is accepted, the information herein is an integral part of the plan. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

HRI to complete			
Group No.	Plan No.	Effective Date	Term of Contract