

## Acadiana Management Group, LLC Dental and Vision

International									Dei	illai aila Visioli	
						EMPLOY	EE ENROL	LLMENT		MPLOYEE CHANGE	
MEMBER INFO	RMATION										
Location					Division Number (For Internal Use Only)			Effectiv	Effective Date		
					Dental: Vision:						
Gender Last N	lame, First N	lame, MI			Date of Birth			Social Security Number			
□ M □ F											
Mailing Address					City/State/Zip			Home Phone			
Date of Hire			☐ Full time 〔	☐ Part time Occupation		N.		Marital Status			
If part time:			If part time:					☐ Marrie	☐ Married ☐ Single		
			Hours worked per week:					Other			
FAMILY INFORMATION (Only those eligible may be enrolled. Use additional paper if needed) (Relationship – If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.)											
child, attach doc	cumentation Gender	of legal of Relation		on. If coverage is o	court ordered, att	tach a copy First Nam		r.)	MI	Date of Birth	
	Gender	Relation	isnip	Last Name		FIISt Naiii	le .		IVII	Date of Birth	
Add	$\square_{M}$	☐ Hus	sband								
	□ <sub>F</sub>	1100	TVIIC								
Change Add		Son	П								
Add Terminate	$\square_{M}$	Son Daugh	Stepson								
Change	□ <sub>F</sub>	Daugh Other									
		All and a second									
Add Terminate	$\square_{M}$	Son Daugh	Stepson								
Change	□ <sub>F</sub>	Daugh Other									
Add		Son									
Add Terminate	$\square_{M}$	Son Daugh	Stepson  Stepdaughter								
Change	$\Box_{F}$	Other									
Add			Stepson								
☐ Add	$\square_{M}$										
Change	□ <sub>F</sub>	Daugh	ter — Stepdaughter								
BENEFIT ELEC	TIONS	Outer .									
Dental Plan 1 (Low) Member Only			mber Only	Member & Spouse	Spouse Member & Child(ren)		Membe	mber & Family V		Waive	
Ameritas					e Member & Child(ren)		Member & Fami				
Dental Plan 2 (High) Ameritas			mber Only	Member & Spouse	mber & Spouse   Member &		Child(ren) Memb		ly	Waive	
Vision			mber Only	Member & Spouse	e Member &	Child(ren)	(ren) Member & Far		ly	Waive	
Community Eye Care						]					
CHANGE											
Requested Effect	tive Date: _		_ ⊔	Dental	Vision						
Type of Change:  Name  Address  Add Dependent  Qualifying Event (Complete Next Section)											
QUALIFYING EV	ENT		☐ <sub>Marriage</sub>	☐ Birth	Adoption Placement for Adoption						
Date of Qualifying Event:/											
If you lost other coverage, was it due to:				☐ Divorce	☐ Death		☐ Termination or reduction in work hours				
☐ Employer contributions for coverage ended				☐ COBRA Exhaus	ted $\Box$	Other	Other				

Last Name, First Name											
OTHER DENTAL COVERAGE OR PRIOR COVERAGE INFORMATION											
Do you or any Dependents have other dental coverage? Policyholder Insurance Com											
□ <sub>Yes</sub> □ <sub>No</sub>											
List Covered Members	Coverage Start Date	Coverage End Date	Policy Number								
OTHER VIOLEN COVERAGE OF OR PRIOR COVERAGE											
OTHER VISION COVERAGE OR PRIOR COVERAGE											
Do you or any Dependents have other vision coverage?	Policyholder	Insurance Company	Insurance Company								
Yes No  List Covered Members	Covernment Chart Data	Cayarana Fad Data	Delias Number								
List Covered Members	Coverage Start Date	Coverage End Date	Policy Number								
NOTES											
I declare that the information I have completed on this appallment form is complete and true. Leuthering any appallment form is completed and true.											
I declare that the information I have completed on this enrollment form is complete and true. I authorize my employer to deduct from my earnings the amount to cover my share of the cost of the contributions for coverage(s) I have elected above.											
Employee Signature:		Date signed									
		-									