Acadiana Management Group, LLC
Dental and Vision

☐ EMPLOYEE ENROLLMENT ☐ EMPLOYEE CHANGE

MEMBER INFORMATION

Location	Division Number (For Internal Use Only) Dental: ________ Vision: _________	Effective Date

Gender ☐ M ☐ F	Last Name, First Name, MI	Date of Birth	Social Security Number

Mailing Address	City/State/Zip	Home Phone

Date of Hire	☐ Full time ☐ Part time If part time: Hours worked per week: ________	Occupation	Marital Status ☐ Married ☐ Single ☐ 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.)

	Gender	Relationship	Last Name	First Name	MI	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Husband ☐ Wife				
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other ___________				
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other ___________				
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other ___________				
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other ___________				

BENEFIT ELECTIONS

Dental Plan 1 (Low) Ameritas	Member Only ☐	Member & Spouse ☐	Member & Child(ren) ☐	Member & Family ☐	Waive ☐
Dental Plan 2 (High) Ameritas	Member Only ☐	Member & Spouse ☐	Member & Child(ren) ☐	Member & Family ☐	Waive ☐
Vision Community Eye Care	Member Only ☐	Member & Spouse ☐	Member & Child(ren) ☐	Member & Family ☐	Waive ☐

CHANGE

Requested Effective Date: ____/____/____ ☐ Dental ☐ Vision

Type of Change: ☐ Name ☐ Address ☐ Add Dependent ☐ Qualifying Event (Complete Next Section)

QUALIFYING EVENT ☐ Marriage ☐ 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 Exhausted ☐ Other ______________________________

Last Name, First Name			
OTHER DENTAL COVERAGE OR PRIOR COVERAGE INFORMATION			
Do you or any Dependents have other dental coverage? ☐ Yes ☐ No	Policyholder		Insurance Company
List Covered Members	Coverage Start Date	Coverage End Date	Policy Number
OTHER VISION COVERAGE OR PRIOR COVERAGE INFORMATION			
Do you or any Dependents have other vision coverage? ☐ Yes ☐ No	Policyholder	Insurance Company	Insurance Company
List Covered Members	Coverage Start Date	Coverage End Date	Policy Number
NOTES			

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 _____