CG Dental Enrollment Form

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

Please Print

EFFECTIVE DATE: *(Month, Day, Year)*

PLEASE MARK APPROPRIATE BOX:

☐ New enrollment ☐ Reinstate
☐ Change ☐ Cancellation - Reason for Cancellation: ☐ Leave employment ☐ Transfer out of network area ☐ Transfer to another plan

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTE: PLEASE COMPLETE ALL INFORMATION

NAME *(Last, First, Middle Initial)* | SOCIAL SECURITY NUMBER | DATE OF BIRTH

ADDRESS | *Apt. #* | *City* | *State* | *Zip Code*

TELEPHONE
Home: ( ) Work: ( )

WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)* ☐ Yes ☐ No

EMPLOYER
Loyola University New Orleans

DATE EMPLOYED

SELECT PLAN:
☐ CG Dental Care HMO ☐ CG Dental PPO ~~☐ CG Traditional~~

EMPLOYEE IDENTIFICATION NUMBER *(if applicable)*

CG DENTAL CARE GROUP #
3197368

DIVISION / CLASS / LOCATION

CONNECTICUT GENERAL GROUP # *(if applicable)*

Please submit proof of student or handicapped status for overage dependents.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

COMPLETE FOR ALL PERSONS TO BE COVERED

RELATIONSHIP	NAME *(include last name if different)*	SOCIAL SECURITY NUMBER	ADDRESS *(if different)*	SEX	DATE OF BIRTH *(Month, Day, Year)*	DENTAL OFFICE SELECTION *(for CG Dental Care only)* 1st Choice	2nd Choice	START DATE OF CONTINUOUS DENTAL COVERAGE *(for CG Dental PPO only)* *(Month, Day, Year)*	*(check one)*
Self		- -		☐ M ☐ F					☐ Add ☐ Cancel
Spouse		- -		☐ M ☐ F					☐ Add ☐ Cancel
Child		- -		☐ M ☐ F					☐ Add ☐ Cancel
Child		- -		☐ M ☐ F					☐ Add ☐ Cancel
Child		- -		☐ M ☐ F					☐ Add ☐ Cancel

I accept the coverage / insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage as indicated on this form. I authorize deduction from my earnings of the required contributions, if any, toward the cost of the coverage.

I authorize payment of dental benefits to the provider of dental care.

I authorize any participating dental office to release dental records and billing information concerning anyone proposed for coverage to Connecticut General Life Insurance Company or its designee(s) for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize Connecticut General Life Insurance Company to release any records or information concerning anyone proposed for coverage to its designee(s), for purposes of plan administration and customer service.

I have read and accept the provisions printed above: | SIGNATURE | DATE

DISTRIBUTION: White - CG **Canary** - Member