HRI DENTAL &VISION

insuringsmiles.com
PO Box 659 Evansville, IN 47704-0659
800-727-1444 Fax: 812-424-2096

ENROLLMENT APPLICATION
ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES AND PROCESS CLAIMS

Group Legal Name:	**Group Number:**	**Site Location:**	**Plan:**

ADD
Coverage Effective Date: _____
☐ Open Enrollment
☐ New Hire
☐ Coverage Lost
☐ Marriage
☐ Divorced or Legal Separation
☐ Birth/Adoption
☐ COBRA (if applicable)

TERM
Coverage Termination Date: _____
☐ Open Enrollment
☐ Employment Termination
☐ Coverage Gained
☐ Death
☐ Reduction of Hours Worked
☐ Divorced or Legal Separation
☐ Over Age Limit
☐ No Longer Full-Time Student
☐ COBRA (if applicable)

UPDATE
Event Date (if applicable): _____
☐ Name Change
☐ Social Security Number
☐ Date of Birth
☐ Address
☐ Coordination of Benefits
☐ Disability
☐ Full-Time Student Status

EMPLOYEE
☐ Add
☐ Term
☐ Update

PRODUCT
☐ Dental Only
☐ Vision Only
☐ Dental and Vision
☐ Waive

Social Security Number | Employee Hire Date

Last Name | First Name | MI | Birth Date

PREFERRED LANGUAGE
☐ English ☐ Vietnamese
☐ Spanish ☐ Other _____

Home Address | City | State | Zip

Phone Number | Email Address

SPOUSE / PARTNER
☐ Add
☐ Term
☐ Update

PRODUCT
☐ Dental Only
☐ Vision Only
☐ Dental and Vision
☐ Waive

Social Security Number | Birth Date | ☐ Disability ☐ Full-Time Student | Other Dental Coverage? ☐ Yes ☐ No

Last Name | First Name | MI | Is Other Policy Primary? ☐ Yes ☐ No

PREFERRED LANGUAGE
☐ English ☐ Vietnamese
☐ Spanish ☐ Other _____

Phone Number | Email Address

DEPENDENT
☐ Add
☐ Term
☐ Update

PRODUCT
☐ Dental Only
☐ Vision Only
☐ Dental and Vision
☐ Waive

Social Security Number | Birth Date | ☐ Disability ☐ Full-Time Student | Other Dental Coverage? ☐ Yes ☐ No

Last Name | First Name | MI | Is Other Policy Primary? ☐ Yes ☐ No

PREFERRED LANGUAGE
☐ English ☐ Vietnamese
☐ Spanish ☐ Other _____

Phone Number | Email Address

DEPENDENT
☐ Add
☐ Term
☐ Update

PRODUCT
☐ Dental Only
☐ Vision Only
☐ Dental and Vision
☐ Waive

Social Security Number | Birth Date | ☐ Disability ☐ Full-Time Student | Other Dental Coverage? ☐ Yes ☐ No

Last Name | First Name | MI | Is Other Policy Primary? ☐ Yes ☐ No

PREFERRED LANGUAGE
☐ English ☐ Vietnamese
☐ Spanish ☐ Other _____

Phone Number | Email Address

DEPENDENT
☐ Add
☐ Term
☐ Update

PRODUCT
☐ Dental Only
☐ Vision Only
☐ Dental and Vision
☐ Waive

Social Security Number | Birth Date | ☐ Disability ☐ Full-Time Student | Other Dental Coverage? ☐ Yes ☐ No

Last Name | First Name | MI | Is Other Policy Primary? ☐ Yes ☐ No

PREFERRED LANGUAGE
☐ English ☐ Vietnamese
☐ Spanish ☐ Other _____

Phone Number | Email Address

Please sign and date second page.

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: 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.

For Iowa and Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer submits an application or files a claim containing a false deceptive statement is guilty of insurance fraud.

Employee_____ Date _____

Employer Benefits Administrator/Authorized Agent_____ Date _____

© 2025 HRI Dental & Vision