

**Must be completed in FULL – PLEASE PRINT** – Enrollment is not valid without signature at the bottom of this page.

Last Name		First Name	
Street Address			
City		State	Zip Code
Home Phone		Date of Birth (MM/DD/YYYY)	
SSN		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Effective Date (MM/DD/YY)		Date of Hire (Required) (MM/DD/YY)	
Employer's Full Name <b>Acuity Surgical Devices</b>			
Employer's Address			
Group Number <b>12008708</b>		Subgroup/Dept. #	

**Coverage Selection** - Confirm available options with your employer. Check all that apply.

**Dental**

Indemnity - Platinum Network

**Insured Vision**

Access Choice:

Vis 7

**Individuals Covered** - List individuals for whom you are enrolling.

Dental <input type="checkbox"/> Enroll	Vision <input type="checkbox"/> Enroll	Spouse Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)

For additional dependents include the Dependent Enrollment Form

Covered by other DENTAL Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of other Dental Insurance Company	Name of Person Insured	Social Security Number
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**Confirmation for Dental and Vision Insurance Coverage**

Authorization  Check here to waive if no coverage is desired  Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

**WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF FRAUDULATING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, that I will not be entitled to any compensation for my non-participation. I further understand I will not be eligible to enroll in this plan again until next enrollment period.

Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_



ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE American Insurance Company.

ace usa