# GROUP EMPLOYEE ENROLLMENT APPLICATION

argus dental vision — a premier benefits organization

| EMPLOYER INFORMATION | |
|---|---|
| Employer Name | Requested Effective Date |

| APPLICANT INFORMATION (PLEASE PRINT) | | | |
|---|---|---|---|
| Last Name (Include Jr., Sr., etc.) | First Name | | M.I. |
| Street Address | Apt Number | City | State/Zip |
| Social Security Number | Home Telephone | | Work Telephone |
| Male ☐ Female ☐ | Date of Birth(MM-DD-YY) / / | | |

| PLAN AND COVERAGE SELECTION | Dental Office Information- Not Required |
|---|---|
| **Master Plan** ☐ Individual ☐ Individual + 1 ☐ Family | Name of Dentist:______________________________ |
| **Freedom Plan** ☐ Individual ☐ Individual + spouse ☐ individual + child ☐ Family | Provider Number (if known)________________________ |

| DEPENDENT INFORMATION | | |
|---|---|---|
| Spouse Name | ☐ Male ☐ Female | Date of Birth (MM-DD-YY) / / |
| Child Name | ☐ Male ☐ Female | Date of Birth (MM-DD-YY) / / |
| Child Name | ☐ Male ☐ Female | Date of Birth (MM-DD-YY) / / |
| Child Name | ☐ Male ☐ Female | Date of Birth (MM-DD-YY) / / |
| Child Name | ☐ Male ☐ Female | Date of Birth (MM-DD-YY) / / |

**DEPENDENTS:** Eligible dependents are determined by your employer's eligibility terms.

## AUTHORIZATION FOR DEDUCTION

I hereby authorize deductions from my salary for any contributions required. I also understand that a full description of services will be provided in the certificate of coverage and that the dentist I select may or may not perform all of the services listed on the Fee Schedule. I authorize the dentist who has rendered services to me or members of my family to make available to Argus Dental & Vision, Inc. my dental records, photocopies or information regarding such services to the extent permitted by law.

If information is not complete and your signature is not present, the application will not be processed. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Argus Dental & Vision, Inc., a Florida corporation, is a Prepaid Limited Health Services Organization licensed under Florida Statutes, Chapter 636. We will provide additional information regarding the terms and conditions of the plan if you call or write us at the number or address below.

**Signature:**________________________________________**Date:**____________________________

## REFUSAL/WAIVER – Complete ONLY if you are declining coverage for yourself or any dependent.

I decline coverage for: ☐ **Myself** ☐ **My Spouse** ☐ **My Children**

Reason:______________________________________________________________________

**Signature:**________________________________________**Date:**____________________________

**FOR MORE INFORMATION, PLEASE CALL: 1.877.864.0625 OR VISIT www.argusdentalvision.com**

**FAX: 813.490.0093 | 4010 W. State Street | Tampa, FL 33609**