SET SEG
School Insurance Specialists

SUBSCRIBER APPLICATION
DENTAL/VISION BENEFITS ONLY

SUBSCRIBER

ENROLLMENT TYPE: ☐ NEW HIRE ☐ REHIRE ☐ OPEN ENROLLMENT ☐ COBRA

REASON: ☐ MARRIAGE ☐ LEGAL GUARDIAN ☐ TRANSFER ☐ LOSS OF COVERAGE

DISTRICT NAME

ACCOUNT #

EFFECTIVE DATE

Please print

SOCIAL SECURITY NO. | NAME (LAST, FIRST, MIDDLE INITIAL)

BIRTH DATE OF EMPLOYEE (MM/DD/YY) | MARITAL STATUS | GENDER

ADDRESS | CITY | STATE | ZIP CODE

JOB TITLE/OCCUPATION | EMPLOYMENT DATE (REQUIRED)

HOURS WORKED/WEEK | ANNUAL SALARY

DEPENDENTS

NAME: (FIRST, LAST IF DIFFERENT)	GENDER	SOCIAL SECURITY NO. (MANDATORY FOR ALL)	BIRTHDATE MM/DD/YY	OTHER INSURANCE?	CHECK IF APPLICABLE
SPOUSE				☐ YES ☐ NO	☐ AGE 19-26 ☐ DISABLED
CHILD				☐ YES ☐ NO	☐ AGE 19-26 ☐ DISABLED
CHILD				☐ YES ☐ NO	☐ AGE 19-26 ☐ DISABLED
CHILD				☐ YES ☐ NO	☐ AGE 19-26 ☐ DISABLED

GROUP PLANS

GROUP **DENTAL**: ☐ YES ☐ NO *If yes,* ☐ EMPLOYEE ☐ EMPLOYEE & DEPENDENT(S)

DENTAL PLAN NAME/CODE

GROUP **VISION**: ☐ YES ☐ NO *If yes,* ☐ EMPLOYEE ☐ EMPLOYEE & DEPENDENT(S)

VISION PLAN NAME/CODE

OTHER INSURANCE

Are you or any family member covered under another group insurance program(s)? ☐ YES — *Please complete below* ☐ NO

NAME OF SUBSCRIBER | SOCIAL SECURITY NO. | DATE OF BIRTH | EMPLOYER

☐ FAMILY ☐ SINGLE

DENTAL INSURANCE COMPANY NAME | EFFECTIVE DATE

☐ FAMILY ☐ SINGLE

VISION INSURANCE COMPANY NAME | EFFECTIVE DATE

SIGNATURES

☐ I have read and understand the conditions on the reverse side of this form.

APPLICANT SIGNATURE | DATE

Signed form must be received within 30 days of requested effective date.

FORM NO. 032 REV. 1/26/15

For questions or to submit form: email enrollment@setseg.org or fax (517) 492-0872