SIHO INSURANCE SERVICES

417 Washington Street
Columbus, IN 47201
800-443-2980

SIHO Dental and Vision Employee Enrollment Form

Employer Name: _____

Effective Date: _____ **Date of Hire:** _____

Employee Information (Please print clearly)

If your employer offers more than one plan option (available for groups with 50 or more employees) please select you plan:

Dental: o **Paramount** ☐ **Preferred** ☐ **Standard** ☐ **Value**

Vision: ☐ **12/12 Plan** ☐ **12/24 Plan**

I am applying for coverage for:

☐ **Employee Only** ☐ **Employee & Spouse** ☐ **Employee & Child(ren)** ☐ **Employee & Family**

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security #_____ Email Address _____

Home Phone _____Work Phone _____Birth Date _____ Hire Date_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please complete the table below for each person that will be covered.

	Last Name	First Name	Social Security #	Birth Date	Sex F/M	Relation to Employee*
01 Self						
02 Spouse						
03 Child						
04 Child						
05 Child						
06 Child						
07 Child						

* C = natural or adopted child. If child is 19-24 and not on SIHO Health Plan, please provide full-time college verification. *O = stepchildren, other blood relatives, or child subject to legal guardianship. If child is not on SIHO Health Plan, please provide full-time college verification or documentation of financial dependency.

If additional dependent information is necessary, please attach a separate sheet of paper.

Does spouse have a dental plan? ☐ Yes ☐ No If "yes," with whom?_____

Group Dental Coverage is provided under SIHO insured by HRI.

Group Vision Coverage is provided under SIHO insured by EyeMed (Insight Network) Vision.

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.

By my signature below, I hereby apply for the coverage or coverages selected above. I also hereby authorize payroll deductions from my earnings for any contributions required. This authorization remains in effect until revoked by me in writing. I have also read the fraud notice above.

_____ _____

Employee Signature Date