DENTAL Enrollment Form

Please type or print clearly using black ink. ***All eligible employees MUST complete this form.***

Texas Ag Coop Trust

EMPLOYEE INFORMATION					
Group Number	Employer Name	Division/Location	Date of Hire/Full Time / /	Effective Date / /	
Name: Last	First	M.I.	Social Security No. - -	Gender ☐ Male ☐ Female	Date of Birth / /
Mailing Address: Street	Apt. No.	City	State	Zip	Home Phone ( )	Work Phone ( )
If declining coverage: YES _____		Hours Worked per Week	Marital Status ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated		Date of Marriage / /

DEPENDENT INFORMATION *(All eligible dependents MUST be listed below.)*									
Relation to Applicant	Name: Last	First	M.I.	Date of Birth	Gender	Social Security No.	Employed?	Is coverage requested for this dependent?	Reason for declining coverage for this dependent?
Spouse				/ /	☐ Male ☐ Female	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other: _____
Child				/ /	☐ Male ☐ Female	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other: _____
Child				/ /	☐ Male ☐ Female	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other: _____
Child				/ /	☐ Male ☐ Female	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other: _____
Child				/ /	☐ Male ☐ Female	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other: _____

Monthly Cost	**Total Cost**	**Your Share**
Employee Coverage	$22.90	$_____
Employee + Spouse	$46.40	$_____
Employee + Child(ren)	$52.50	$_____
Employee + Spouse & Child(ren)	$68.38	$_____

I understand that my coverage election is irrevocable and will continue for the plan year unless there is a significant family status change, such as marriage, divorce, death, birth or change in the employment status of my spouse.

I acknowledge that the available coverages have been explained to me by my employer. I hereby apply for the coverage now being offered to me and my dependents, if any, as shown above. If accepted as a group member, my employer is authorized to deduct the appropriate amount from my earnings and remit it to TACT. I hereby declare that all answers above are true and complete and that any material misstatements or failure to report information may be used as the basis for rescission of coverage for me and my dependents, if any, from the original effective date. I further understand that if the coverage applied for becomes effective, I will be subject to all the terms of the plan. I authorize any physician, dentist, medical practitioner, hospital, clinic or other medical related facility, insurance company or other organization, employers, or other person that has any information available as to my health or that of any member of my family to give to TACT or its legal representative any such information. I was not induced or pressured into declining coverage because of my health status or that of my dependents, if any. I further understand that in the event I should decide to apply for coverage at a later date that I may not be able to apply for this coverage until the annual Open Enrollment Period. A photocopy of this authorization shall be as valid as the original.

_____ _____ _____

Employee signature | Date | Authorized Employer Signature *(if required)*

WARNING: It is unlawful to knowingly provide false, incomplete or misleading facts or information for the purpose of defrauding or attempting to defraud the Plan. Penalties may include imprisonment, fines, denial of coverage and civil damages.