

DENTAL BENEFITS APPLICATION

_____ Last Name	_____ First Name	_____ Middle Initial	_____ Effective Date of Coverage
_____ Address			_____ Date of Hire
_____ City	_____ State	_____ Zip Code	_____ Phone Number
_____ Soc. Sec. Number		_____ Email Address	

BENEFITS ELECTION: Please Check One:

- Single Coverage
- Single & Spouse Coverage (Fill out DEPENDENT INFORMATION)
- Family Coverage (Fill out DEPENDENT INFORMATION)

DEPENDENT INFORMATION: If you elect Single & Spouse or Family Coverage please complete the following:

Name of Spouse/Dependent:	D.O.B.	Gender	Social Security Number	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IF CURRENTLY COVERED ELSEWHERE, PLEASE COMPLETE THE FOLLOWING:

_____ Employer Company Name	_____ Insurance Company	_____ Policy Holder	_____ Members
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I apply for coverage for each person listed and agree that we will abide by the Certificate of Coverage or Summary Plan Description. I authorize any person or entity having information regarding our medical/dental care to release that information to American Employers Group. Photo copies of this authorization may be used until I revoke authorization in writing. I agree that no claims will be covered until this application is approved by American Employers Group, or unless stated in my Summary Plan Description.

_____ Signature	_____ Date
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HEALTH INFORMATION AUTHORIZATION

I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related (dental or vision) facility, Medical Information Bureau; Inc. or insurance companies that possess health information about me to furnish all such health information to A.E.G. hereinafter called the Company, upon presenting this Authorization or a photocopy.

Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to re-insurers or authorized business associates, who may be involved with my application for insurance or otherwise permitted or required by law, in which case it may not be protected under federal privacy rules, acknowledge that I have read this Authorization, understand, and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, A.E.G., PO Box 50 Caledonia, MI 49316. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company. Revocation of this authorization may result in the refusal of the Company to offer insurance coverage or pay benefits under a policy which has been issued.

Signature of Proposed Insured or Parent if Proposed Insured is under 18

Date

Print Name of Proposed Insured

Application Number, if known

NOTE TO MEDICAL PROVIDERS This Authorization is designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 also know as HIPAA.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Patient name: _____

ID Number: _____

Persons/organizations authorized to provide the information: Dentists, and VSP Facilities and A.E.G. _____

Persons/organizations authorized to receive the information: Dentists, and VSP Facilities and A.E.G. _____

Specific description of information to be used or disclosed (including date(s)): Benefit Insurance only _____

Specific purpose for the disclosure: to discuss benefits _____

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No X Yes (describe) _____

This authorization will expire when employee benefits change or expire (indicate date, or an event relating to you personally or to the purpose of the authorization). _____

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I asked for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.
[Editor's Note: The last sentence about the right to seek assurances from the receiving entity is not required by HIPAA, but may be helpful to remind patients of their rights.]

III. Signature of Patient or Patient's Representative

Signature of patient or patient's representative
(Form MUST be completed before signing.)

Date

Printed name of the patient's personal representative

Relationship to the patient, including authority for status as representative

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION