SECURITY LIFE INSURANCE COMPANY OF AMERICA
Minnetonka, Minnesota

eHealthInsurance.com
EyeCare Solutions
DentalCare Solutions

Dental & Vision Employee Enrollment Form

		/ / Mo. Day Yr.	M ☐ F ☐	**For Company Use Only**
Social Security No.	Applicant's Name (Last/First/ Initial)	Birth Date	Sex	Effective Date
		☐Married ☐Single ☐Widowed ☐Divorced		Plan Code
Home Address (City/State/Zip)	Telephone No.: ( )	Marital Status		
			Waiver	CPT
Name of Employer or Organization (if applicable)		Full-Time Hire Date (if applicable)		
		( )	Group Number	Division Number
Address (City/State/Zip) (if applicable)		Telephone No:		

ADDITIONAL INFORMATION (if applicable)

☐ New Enrollment ☐ Family Addition ☐ New Hire (if applicable) ☐ Re-hire (if applicable) ☐ Decline ☐ Termination-Reason:

FAMILY INFORMATION List only those eligible family members who are enrolling

Relationship	Sex M / F	Last Name	First Name	M.I.	Birth Date	Full-Time Student Y / N

COVERAGE SELECTION

☐ Group Dental Coverage provided under the Group Dental Policy issued to the Trusteed Group Policyholder

I apply for group dental coverage for:
☐ Myself only
☐ Myself and Eligible Dependents

1. Does Spouse have a dental plan? ☐ Yes ☐ Insurer Name:

☐ Group Vision Coverage provided under the Group Vision Policy issued to the Group Policyholder (policyholder may be trusteed group policyholder in some states)

I apply for group vision coverage for:
☐ Myself only
☐ Myself and Eligible Dependents

BY MY SIGNATURE BELOW, I HEREBY APPLY FOR THE COVERAGE OR COVERAGES SELECTED ABOVE.

_____
Applicant's Signature Date

I HEREBY AUTHORIZE PAYROLL DEDUCTIONS FROM MY EARNINGS FOR ANY CONTRIBUTIONS REQUIRED.

_____
Applicant's Signature Date

THIS AUTHORIZATION REMAINS IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Plan Identification:

_____

_____

Administrator:

JLT Services Corporation
PO Box 1471
Waterbury, CT 06721
Phone: (877) 862-8949 (toll-free)
Fax: (203) 754-3941