CPM, INC.
EMPLOYEE ENROLLMENT FORM
DENTAL AND VISION ONLY

Social Security Number	Plan Name **OGLALA LAKOTA COLLEGE**	Plan Number **1715**	Date of Full Time Employment	
Employee Name LAST FIRST MIDDLE INIT		Date of Birth	Sex	Marital Status
Home Address			Home Phone Number	
Occupation / Title			# Hours Worked Per Week	

IF YOU ARE DECLINING COVERAGE FOR YOU OR YOUR DEPENDENTS, READ AND SIGN THE WAIVER BELOW

Enrollment Information:	☐ Single	☐ Family	☐ Waive*
Employee Coverage:	☐ Dental	☐ Vision	☐ Waive*
Dependent Coverage:	☐ Dental	☐ Vision	☐ Waive*

PLEASE LIST SPOUSE AND ALL CHILDREN UP TO AGE 26, WHETHER ENROLLING IN COVERAGE OR NOT
(Attach Additional Sheet if Necessary – Information Required By IRS as part of Healthcare Reform)

Name of Eligible Family Member(s)	Covered	Sex	Date of Birth	Social Security Number
Spouse	Yes No			
Child	Yes No			
Child	Yes No			
Child	Yes No			
Child	Yes No			

Do you and/or a member of your family have other dental or vision insurance in addition to Employer Dental and Vision Plans administered by Corporate Plan Management? ____ Yes ____ No
If yes, complete Section(s) A, B (if applicable), and C. If no, complete Section C on the reverse side.

AUTHORIZATION: I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my dependents or my health to give to the Plan Administrator any such information. A photographic copy of this authorization shall be valid as the original.

_____ **X**_____ _____

Signature Date | Signature of Employee | Effective Date (First of the month following 30 days)

*WAIVER (DECLINATION) OF COVERAGE

I, the undersigned, hereby waive eligibility for coverage: For myself and my dependents☐ For my dependents ☐ For my spouse ☐

Reasons for declining this coverage: (MUST BE COMPLETED)

Other Group Insurance: (name company)_____

Other reason: _____

I understand that if I decline coverage during my initial eligibility period, neither me nor my dependents will be eligible for coverage in the future, except under Special Enrollment provisions or Open Enrollment period as explained in the group Plan Document.

_____ Date : _____

Signature of Employee

SECTION A: OTHER INSURANCE COMPANY INFORMATION (Attach additional page(s) if there is more than one other insurance policy.)

Other Insurance Name, Address, Street, City, Zip			
Type of Coverage:( )Single ( )Employee & Child Only ( )Children Only (Family ( )Employee & Spouse ( )Spouse Only			
Name of Policy Holder		Date of Birth	Policyholder's Gender: ( ) Male ( ) Female
Other Insurance Policy #	Group No.	Other Insurance Phone #	Policy Effective Date ____/____/_____
Employees in Group: ( ) Less than 20 ( ) 20 or more ( ) 100 or more ( ) Unknown			

Persons Covered by Other Insurance	Date of Birth	Relationship	Social Security No.
1.			
2.			
3.			
4.			

SECTION B: COMPLETE THIS SECTION IF YOU HAVE DEPENDENT CHILDREN AFFECTED BY A DIVORCE, LEGAL SEPARATION, COURT DECREED CUSTODY/GUARDIANSHIP, OR CHILD SUPPORT ORDER.

Does a court decree state who has financial responsibility for providing health coverage for any dependent?

( ) NO ( ) YES, the court decree specifies that_____has responsibility.

Child's Name	Custodial Parent(s) Name and Month/Day of Birth	Non Custodial Parent(s) Name and Month/Day of Birth	Joint Custody Yes/No	Person with whom child lives

Provide a copy of the insurance card for each policy that covers the dependents listed above.

SECTION C: This section must be completed and signed by the subscriber.

To the best of my knowledge the information provided is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, or any other insurance carrier or plan to make available to Corporate Plan Management all information concerning claims filed by me or on my behalf.

Subscriber's Signature	Date of Birth	Work Phone No.	Home Phone No.	Today's Date