LINDSEY WILSON COLLEGE
PARAMOUNT DENTAL CHANGE FORM
FOR PLAN YEAR 2024

I hereby elect the following dental plan for the 2024 plan year.

☐	Single Core Plan MO	$15.78
☐	Single Buy Up Plan MO	$25.19
☐	Family Core Plan MO	$57.33
☐	Family Buy Up Plan MO	$95.68
☐	EE + Spouse Core Plan MO	$34.76
☐	EE + Spouse Buy Up Plan MO	$56.80
☐	EE + Child(ren) Core Plan MO	$38.27
☐	EE + Child(ren) Buy Up Plan MO	$62.33

☐	Single Core Plan BW	$7.89
☐	Single Buy Up Plan BW	$12.60
☐	Family Core Plan BW	$28.67
☐	Family Buy Up Plan BW	$47.84
☐	EE + Spouse Core Plan BW	$17.38
☐	EE + Spouse Buy Up Plan BW	$28.40
☐	EE + Child(ren) Core Plan BW	$19.14
☐	EE + Child(ren) Buy Up Plan BW	$31.17

☐ I waive participation in the 2024 dental insurance plan year.

_____ _____
Print Name Employee L#

_____ _____
Signature Date

PARAMOUNT DENTAL
Affiliate of ProMedica

InsuringSmiles.com
PO Box 659 Evansville IN 47704-0659
Phone: (800) 727-1444 - Fax: (812) 424-2096

ENROLLMENT APPLICATION

ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES, AND PROCESS CLAIMS

Group Legal Name:	**Group Number:**	**Site Location / Cabinet:**	**DHO Plan:**
Lindsey Wilson College	0929220726LI; 0929220727LI		☐ Core Plan ☐ Buy Up Plan

ADD	**TERM**	**UPDATE**
Coverage Effective Date:______________	Coverage Termination Date:______________	Event Date (if applicable):______________
☐ Open Enrollment ☐ New Hire ☐ Coverage Lost ☐ Marriage ☐ Divorced or Legal Separation ☐ Birth / Adoption ☐ COBRA (if applicable)	☐ Open Enrollment ☐ Employment Termination ☐ Coverage Gained ☐ Death ☐ Reduction of Hours Worked ☐ Divorced or Legal Separation ☐ Over Age Limit ☐ No Longer Full Time Student ☐ COBRA (if applicable)	☐ Name Change ☐ Social Security Number ☐ Date of Birth ☐ Address ☐ Coordination of Benefits ☐ Disability ☐ Full Time Student Status

EMPLOYEE ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental Only ☐ Vision Only ☐ Dental & Vision	Social Security Number	Employee Hire Date
		Last Name / First Name / MI	Birth Date
		Home Address / City	State / Zip

SPOUSE / PARTNER ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental Only ☐ Vision Only ☐ Dental & Vision	Social Security Number Last Name	Birth Date First Name / MI	Other Dental Coverage? ☐ Yes ☐ No Is Other Policy Primary? ☐ Yes ☐ No
DEPENDENT ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental Only ☐ Vision Only ☐ Dental & Vision	Social Security Number Last Name	Birth Date / ☐ Disability ☐ Full Time Student First Name / MI	Other Dental Coverage? ☐ Yes ☐ No Is Other Policy Primary? ☐ Yes ☐ No
DEPENDENT ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental Only ☐ Vision Only ☐ Dental & Vision	Social Security Number Last Name	Birth Date / ☐ Disability ☐ Full Time Student First Name / MI	Other Dental Coverage? ☐ Yes ☐ No Is Other Policy Primary? ☐ Yes ☐ No
DEPENDENT ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental Only ☐ Vision Only ☐ Dental & Vision	Social Security Number Last Name	Birth Date / ☐ Disability ☐ Full Time Student First Name / MI	Other Dental Coverage? ☐ Yes ☐ No Is Other Policy Primary? ☐ Yes ☐ No

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Employee____ Date______________

Employer Benefits Administrator/Authorized Agent______________________ Date______________