



**ADP/POS/Dual CL
GROUP ENROLLMENT, WAIVER,
AND CHANGE REQUEST FORM**



9725 E Hampden Avenue #400
Denver, CO 80231
1-800-807-0706 (Phone)
303-744-2890 (Fax)

- New Employee Change Address
 COBRA Change Dependent Status
 Terminate Coverage*

* Can only terminate coverage at open enrollment or if employment is terminated.

TO BE COMPLETED BY EMPLOYER	Companion Group No. 111-04-74415	Div.	Class
Name of Employer (Use Name from Group Billing Notice or Master Application) StaffScapes	Beta Health Group No. (4 digit #) 4490		

TO BE COMPLETED BY EMPLOYEES ELECTING TO ENROLL												
Social Security Number			Effective Date			Date Employed Full Time			Date of Birth			Hours Worked Per Week
			Month	Day	Year	Month	Day	Year	Month	Day	Year	
Your Name Last				First				M.I.				Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Your Home Address			City			State			Zip Code		

Dental Options (please check your selection)

Alpha Dental Plan only** Provider Selection: ADP # _____

CarePOS Dental Plan only

Companion Life Dental Plan A

Companion Life Dental Plan B

** You must select a plan provider for all services. Please visit www.betadental.com for a current provider directory. The Alpha and CarePOS dental plan options are discount fee for service dental plans and are in no way considered insurance. Alpha dental providers can be changed at any time by calling 303-744-3007 or 1-800-807-0706.

COMPLETE FOR DENTAL					
Is your spouse to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Coverage Is For (Check Box Below):				Are you or any of your dependents covered for dental insurance under another policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee plus 1	<input type="checkbox"/> Employee plus 2	<input type="checkbox"/> Employee plus 3 or more	

Complete for Dependent Coverage				Full-time	Date of Birth	Gender	Do any of your dependents have any other dental coverage?	If Yes, Name of Carrier
Spouse Name	(Last)	(First)	(Middle Initial)	Student Y/N	/ /	M or F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
C H I L D R E N	1				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	6				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

WAIVER OF COVERAGE

I have been offered the above plans and decline to purchase one or all of these plans at this time. I understand that in the event I desire such benefits at a later date, the company will have the right to refuse any request.

Coverage Refused (Check All That Apply): Dental

Date _____ Signature of Employee _____

I elect the above coverage which I have checked from those for which I am eligible, and I decline the above coverage which I have not checked from those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the plan, then I authorize my employer to deduct the contribution from my wages.

Date	Your Signature X
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