Southland National Insurance Corporation

P.O. Box 1520
Tuscaloosa, AL 35403-1520
Phone: 1-866-839-5308
Fax: (205) 343-1239

DENTAL & VISION PLAN ENROLLMENT / CHANGE FORM

Part 1

Plans Desired:

Dental Program

☐ Base Plan

☐ Buy Up Plan (if Available)

☐ **VisionChoice® ***

Check One:

☐ New Subscriber

☐ Open Enrollment

☐ Add/Delete Dependent

☐ Terminate Coverage

☐ Other _____

Part 2

Name of Employer / Group: _____ Location: _____

Primary Enrollee Information

Name: _____
First MI Last

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____
Month Day Year

SSN#: _____ - _____ - _____ Marital Status: ☐ Single ☐ Married

Mailing Address: _____ Apt #: _____
Street

City: _____ State: _____ Zip: _____

Phone #: (_____) _____-_____ Membership/Hire Date: _____/_____/_____

Email: _____

Coverage Desired: ☐ Single ☐ Single + One Child ☐ Single + Spouse ☐ Family

Do you have dependent children? ☐ Yes ☐ No

Covered Dependent Information (Name)	Add	Delete	Male	Female	Date of Birth
Spouse _____ (First MI Last)	☐	☐	☐	☐	____/____/____
Dependent _____ (First MI Last)	☐	☐	☐	☐	____/____/____
Dependent _____ (First MI Last)	☐	☐	☐	☐	____/____/____
Dependent _____ (First MI Last)	☐	☐	☐	☐	____/____/____

Are you or your dependents covered under another dental or vision plan? ☐ Yes ☐ No

If yes, name of other insurer / carrier: _____

Are all listed dependent children under age 19 or full-time students under age 25? ☐ Yes ☐ No

Part 3

☐ I hereby apply for benefits for which I am eligible. I authorize any deduction that may be required towards the cost of this program. I certify that the information in this form is true and correct to the best of my ability. This program does not become effective until approved by Southland National Insurance.

☐ I decline the dental program at this time.

☐ I decline the vision program at this time.

Insurance Notice: Any person who knowingly and with intent to injure, defraud, or deceive files a statement of claim or an application with any false, incomplete, or misleading information is guilty of insurance fraud.

Signature of Subscriber: _____ Date: _____

SNIC-GDE2006

ENROLLMENT INSTRUCTIONS:

1. **Part 1**: Select the plan(s) for which you are enrolling in and check the box describing the status of your application.
2. **Part 2:** Fill in all demographic information, being sure to include the names of all dependents you wish to include on your plan.
3. **Part 3:** Check the authorization for deduction box and sign your name at the bottom. Return the completed application to Human Resources or appropriate party.

Completed applications received by Southland National Insurance by the 15th of the month will become effective on the 1st of the following month.

*VisionChoice® is a benefit program administered by Southland Benefit Administrators. This is a non-insurance product.

For Southland Use Only:

Date Received: _____

Effective Date: _____

Group No: _____

Account No: _____

Monthly Cost: _____

Plan Code: _____

Date Entered: _____