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

ADP/POS/Companion GROUP ENROLLMENT, WAIVER, AND CHANGE REQUEST FORM

THREE TIER

☐ New Employee ☐ Change Address
☐ COBRA ☐ Change Dependent Status
☐ Terminate*

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

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)	Companion Group #	Div.	Class
	Beta Health Group #		

TO BE COMPLETED BY EMPLOYEES ELECTING TO ENROLL

Social Security Number			Effective Date			Date of Hire			Date of Birth			Phone #
			Month	Day	Year	Month	Day	Year	Month	Day	Year	Work: ______ Home: ______

Your Name Last | First | M.I. | Gender ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married | Your Home Address | City | State | Zip Code

E-mail Address:

Dental Options (please check your selection)

Alpha Dental Plan only** ☐ Provider Selection: ADP # ____________

CarePOS Dental Plan only ☐

Companion Life Dental Plan only ☐

**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 enrolled?	Enrollment Selection (Check the Correct Box Below):			Are you enrolled in any other dental plans?
☐ Yes ☐ No	☐ Employee Only	☐ Employee Plus One	☐ Employee Plus Two or more	☐ Yes ☐ No

Complete for Dependent(s)

Spouse Name (Last) (First) (Middle Initial)	Full-time Student Y/N	Date of Birth	Gender M or F	Do any of your dependents have any other dental plan?	If Yes, Name of Carrier
		/ /		☐ Yes ☐ No	
DEPENDENT(S) 1		/ /		☐ Yes ☐ No	
2		/ /		☐ Yes ☐ No	
3		/ /		☐ Yes ☐ No	
4		/ /		☐ Yes ☐ No	
5		/ /		☐ Yes ☐ No	
6		/ /		☐ Yes ☐ No	

DENTAL PLAN WAIVER

I have been offered the above dental plan options and I am declining participation at this time. I also understand that the next time that I may enroll in one of these plans is at the next open enrollment period only (one year from now). The only exception to this is if a qualifying event occurs.

Date ____________ Signature of Employee ____________

It is unlawful to knowingly provide false, incomplete, or misleading facts on this form or to defraud or attempt to defraud Beta Health or one of their partners. Penalties may include imprisonment, fines, denial of services and civil damages. Please report any organization or agent who you feel knowingly provides false, incomplete or misleading facts for the purpose of defrauding the participants to the Colorado Division of Insurance. I also agree to remain on the plan for a minimum of one year or until the next open enrollment period (which ever comes first). The only exception to this is if I loose employment (either voluntarily or involuntarily).

Date	Your Signature X