camco benefit services

FAX (360) 438-6256
www.camcobenefits.com

Voluntary Dental Enrollment/Change Form

The Standard Insurance Company

Mark all boxes and complete all sections that apply. Return completed form to Camco Benefit Services

APPLICANT

Your Name (Last, First, Middle)						Group Number(s) 647035
Your Address			City	State	ZIP	Phone Number
Your Soc. Sec. No.	Date of Birth	Gender	Local #	E-mail Address		Job Title/Occupation

DENTAL

Dental ☐ Low Dental Plan ☐ High Dental Plan ☐ Orthodontic Dental Plan

Marital Status ☐ Single ☐ Married ☐ Divorced

Coverage requested for ☐ You, your Spouse and Children ☐ You and your Spouse ☐ You only ☐ You and your Children (no Spouse)

Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more Dependents? ☐ Yes ☐ No

List Dependents to enroll or delete. (Last name if different, First, Middle Initial)	Sex M	Sex F	Date of Birth	*List Dependents to enroll or delete.* (Attach sheet for additional Dependents if needed.)	Sex M	Sex F	Date of Birth
Spouse				Child 2			
Child 1				Child 3			

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Add Dependent ☐ Delete Dependent ☐ Name Change

Date of add/delete _____ Former name _____ ☐ Other _____

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)

Retain a copy of this form for your records

Date of Hire/Rehire	Hrs. Worked Per Wk.

Camco Benefit Services

800 845 4669

EMAIL OR SIGN UP ONLINE: www.camcobenefits.com

Camco Benefit Services

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

(Automated Clearing House Debits, ACH)

NAME (PLEASE PRINT)_____ **PHONE**_____

EMAIL_____**UNION.LOCAL#**_____

I (we) hereby authorize **Camco** to initiate debit entries to my (our) account indicated below and financial institution named below to debit the same such account. **I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.**

☐**CHECKING or** ☐**SAVINGS** (account type)

☐**BI-WEEKLY or** ☐**MONTHLY (the 10th of the month)** (debit type)

BANK NAME_____

TRANSIT/ROUTING/ABA NUMBER_____

ACCOUNT NUMBER_____

This authorization is to remain in full force and in effect until CAMCO has received WRITTEN notification of TERMINATION in such time and in such manner to afford CAMCO and DEPOSITORY a reasonable opportunity to act.

SIGNED_____ DATE ____/____/_____

This dental/vision agreement is active for a period of 12 months from your initial effective date. **An Early Termination Fee of $100 will be assessed for any policy terminated by employee/client prior to completion of their 12-month agreement.**

THERE WILL BE A **$35.00** SERVICE FEE FOR ANY RETURNED ITEMS OR INSUFFICIENT FUNDS.

Please Mail To:

Camco Benefit Services - PO BOX 5667- Lacey, WA 98503

EMAIL OR SIGN UP ONLINE:

www.CAMCOBENEFITS.COM

CAMCO BENEFIT SERVICES
800-845-4669
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