

## DENTAL ENROLLMENT FORM

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please complete the applicable "Type of Activity" change(s) in Section A along with the identification number and employee name in Section B and Section C for dependent changes.

SECTION A: GENERAL INFORMATION		Effective Date (mm/dd/yyyy) ____/____/____
<b>1. TYPE OF PROGRAM</b> <input type="checkbox"/> FFS (Indemnity, Active PPO, Passive PPO - Please Specify) <input type="checkbox"/> Concordia Access <input type="checkbox"/> Concordia Choice <input type="checkbox"/> Concordia Flex <input type="checkbox"/> Concordia Preferred <input type="checkbox"/> Concordia Select <input type="checkbox"/> Other _____ <input type="checkbox"/> DHMO (Please Specify) <input type="checkbox"/> Concordia Plus <input type="checkbox"/> Other _____	<b>2. TYPE OF ACTIVITY</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Cancel All Coverage (Employee & All Dependents) <input type="checkbox"/> Cancel Dependent(s) Only (List dependents to be cancelled) <input type="checkbox"/> Change (Please Specify) <input type="checkbox"/> Add Dependent (e.g., spouse, domestic partner, child, etc.) <input type="checkbox"/> Change Address <input type="checkbox"/> Reinstate Coverage <input type="checkbox"/> Change Name <input type="checkbox"/> Change Group Number <input type="checkbox"/> Change Provider <input type="checkbox"/> COBRA <input type="checkbox"/> Other _____	<b>SECTION E: FOR EMPLOYER USE ONLY</b>  <b>EMPLOYER INFORMATION</b> Employer Name _____  Group Number _____  Sub Group _____  UCCI Payroll Location _____

**SECTION B: EMPLOYEE INFORMATION - Please print clearly to expedite your request.**

1. Identification Number (For example, Social Security Number) _____	2. Original Employment Date (mm/dd/yyyy) ____/____/____		
3. Employee Name (Last, First, Middle Initial) _____	4. Date of Birth ____/____/____	5. Sex _____	6. Provider Number (DHMO Only) _____
7. Home Address _____	City _____	State _____	Zip Code _____

**SECTION C: DEPENDENT INFORMATION** Please list the added/cancelled dependents in this section. For more than five dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time students age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

1. Identification Number (For example, Social Security Number)	2. Type	3. Last Name	4. First Name	5. MI	6. Sex	7. Date of Birth	8. Provider Number (DHMO Only)
_____	Spouse/Domestic Partner						
_____	Dependent (A)						
_____	Dependent (B)						
_____	Dependent (C)						
_____	Dependent (D)						
_____	Dependent (E)						

**SECTION D: OTHER DENTAL COVERAGE** Do you or your dependent(s) have other Group Dental Coverage? Yes  No   
 If your answer is yes, please complete the following information.

Policy Holder	Insurance Company	Policy/Identification Number	Effective Date (mm/dd/yyyy) ____/____/____
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I represent that all information supplied in this application is true and correct. 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 Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer Signature \_\_\_\_\_ Phone Number \_\_\_\_\_ Date \_\_\_\_\_