UNITED CONCORDIA

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) ___ ___/___ ___/___ ___ ___ ___

1. TYPE OF PROGRAM

☐ **FFS**
(Indemnity, Active PPO, Passive PPO - Please Specify)
- ☐ Concordia Access
- ☐ Concordia Choice
- ☐ Concordia Flex
- ☐ Concordia Preferred
- ☐ Concordia Select
- ☐ Other _____

☐ **DHMO** (Please Specify)
- ☐ Concordia Plus
- ☐ Other _____

2. TYPE OF ACTIVITY

☐ **New Enrollment**

☐ **Cancel Coverage**
- ☐ Cancel All Coverage (Employee & All Dependents)
- ☐ Cancel Dependent(s) Only (List dependents to be cancelled)

☐ **Change** (Please Specify)
- ☐ Add Dependent (e.g., spouse, domestic partner, child, etc.)
- ☐ Change Address
- ☐ Reinstate Coverage
- ☐ Change Name
- ☐ Change Group Number
- ☐ Change Provider
- ☐ COBRA
- ☐ Other _____

SECTION E: FOR EMPLOYER USE ONLY

EMPLOYER INFORMATION

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) ___ ___/___ ___/___ ___ ___ ___

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