3831

UNITED CONCORDIA® Dental Enrollment Form

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please select the applicable "Type of Activity" in Section A and provide the identification number and employee name in Section C (also complete Section D for dependent changes).

Fill in circles completely: ● Correct ⊗ Incorrect

For best results, print in capital letters and avoid contact with edge of box. Example: A B C

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

- O **FFS—Indemnity, Active PPO, Passive PPO** (Please specify)
  - O Concordia Access
  - O Concordia Choice
  - O Concordia Flex
  - O Concordia Preferred
  - O Concordia Select
  - O Other_____
- O **DHMO** (Please specify)
  - O Concordia Plus
  - O Other_____

Provider Number (DHMO only)

2. TYPE OF ACTIVITY

- O **New Enrollment**
- O **Cancel Coverage**
  - O Cancel All Coverage (Employee & All Dependents)
  - O Cancel Dependent(s) Only (List dependents to be cancelled in Section D)
  - O Cancel Spouse Only (List spouse to be cancelled in Section D)
- O **Change (Include Group Number in Section B)**
  - O Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - O Change Address
  - O Reinstate Coverage
  - O Change Group Number
  - O Change Provider
  - O Change Name
  - O To COBRA Group
  - O Other_____

Effective Date (mm/dd/yyyy) / /

SECTION B: EMPLOYER USE ONLY

Employer Name

Group Number (9 digits)

UCCI Payroll Location

SECTION C: EMPLOYEE INFORMATION—Please print clearly to expedite your request.

Identification Number (Social Security Number) **Date of Birth** (mm/dd/yyyy) / / **Sex** **Original Employment Date** (mm/dd/yyyy) / /

First Name **M.I.** **Last Name**

Home Address

City **State** **ZIP Code**

SECTION D: DEPENDENT INFORMATION—Please list the added/cancelled dependents in this section. For more than six dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student 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.

Spouse/Domestic Partner

#1 **Identification Number** (Social Security Number) **Date of Birth** (mm/dd/yyyy) / / **Sex** **Provider Number** (DHMO only)

First Name **M.I.** **Last Name**

Dependent

#2 **Identification Number** (Social Security Number) **Date of Birth** (mm/dd/yyyy) / / **Sex** **Provider Number** (DHMO only)

First Name **M.I.** **Last Name**

#3

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) / / | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#4

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) / / | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#5

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) / / | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#6

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) / / | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

SECTION E: 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.

Policyholder Name (First, M.I., Last)	**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 | **Phone Number** | **Email Address** | **Date**

Employer Signature | **Phone Number** | **Date**