Enrollment Form

Group Dental Coverage

Provided by Dental Benefit Providers of California, Inc.

UnitedHealthcare Dental®

Check the Appropriate Boxes

Requested Effective Date of Coverage / Date of Change: / / ☐ Enroll ☐ Cancel ☐ Change

Reason: ☐ New Group Plan ☐ New Hire ☐ Annual Open Enrollment ☐ Address Change ☐ Name Change ☐ Employee Terminated ☐ Marriage ☐ Divorce ☐ Death ☐ Birth ☐ Adoption/Legal Custody ☐ Court ordered Dependent ☐ Dependent married/reached age limit ☐ Cobra/State Continuation ☐ Other:

Employee Information

Social Security Number: - -
Date of Birth: / /

Last Name:
First Name:
Middle Initial:

Address:

City:
State:
Zip Code:

Home Phone:
Work Phone:
Email Address:

Sex: ☐ Male ☐ Female
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Product Selection

Plan Coverage: ☐ Employee Only ☐ Employee + Spouse (or Domestic Partner) ☐ Employee + Child(ren) ☐ Family

If your Employer offers you a choice of dental plan, please indicate your Plan selection (e.g., Options PPO, Indemnity, DHMO, INO℠), and Plan Code (e.g., P1211).

Plan:

Plan Code:

Family Information

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number	Date of Birth	Sex	Relationship**	Full-time Student
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	☐ Spouse ☐ Domestic Partner	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

Other Dental Coverage Information

On the day this coverage begins, will you, your Spouse (or Domestic Partner), or any of your Dependents be covered under any other dental plan, policy or contract including another [Dental Benefit Providers of California, Inc.] dental plan or Medicare? ☐ Yes ☐ No

Spouse (or Domestic Partner) Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:

Primary Dentist Information

Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered Dependents

Insured Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Spouse (or Domestic Partner*) Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Dependent Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Dependent Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Dependent Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:

Employee/Applicant Signature
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Evidence of Coverage. I understand there may be instances where treatment decisions made by my Dentist or me for dental expenses which I have incurred may not be covered by my dental benefit plan.

The Evidence of Coverage provides dental benefits only. Review your Evidence of Coverage carefully.

California Law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FRAUD WARNING STATEMENT: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits

Employee/Applicant Signature:	Date: / /

To Be Completed by Employer

Employer Name:			Enrollee Effective Date: / /	Class Code:
Enrollment: ☐ New Hire ☐ Other	Date of Hire: / /	Contract Number:	Plan Variation/ Reporting Code:	Plan Code:
Employer Authorization:				

UnitedHealthcare Dental insurance products are underwritten or provided by: Dental Benefit Providers of California, Inc.

DHMO-ENROLL-CA