

 **To speed enrollment process,
please be thorough and fill out all sections that apply.**

Groups with 2 to 50 employees

Enrollment Application/Change/Cancellation Request for Dental Coverage

Dental Benefits provided by:
United HealthCare Insurance Company

To speed enrollment process, please be thorough and fill out all sections that apply.

- Enroll
 Cancel
 Change
 Address Change
 Name Change
 Date of Change ___/___/___

A. Employee Information

First Name	M.I.	Last Name	Social Security #			
Street Address	Apt. #	City	County	State	Zip	Country
Home Phone	Work Phone	How many hours do you work per week?		Email Address <input type="checkbox"/> Home <input type="checkbox"/> Work		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Physician		Physician's ID No.	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

B. Family Information

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

Check appropriate box	Last Name	First Name	M.I.	Sex	Relationship	Full-Time Student	Physician	Are you a Current Patient?
	Dependent Social Security No.						Physician's ID Number	
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO

C. Product Selection (check all that apply)

DENTAL BENEFITS:

- Employee Only Coverage
 Employee/Spouse Coverage
 Employee/Children Coverage
 Employee/Spouse/Children Coverage
 I decline coverage for myself
 I decline coverage for my dependents
 Reason: Covered under another plan
 Other: _____

D. To Be Completed By Employer

Company Name	Group #	Plan Variation	Medical Dental _____	Report Code	Date of Employment
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<input type="checkbox"/> New Enrollment/Additions: (Check one) Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Court ordered dependent (attach documentation) <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/Continuation start date _____ stop date _____ <input type="checkbox"/> Annual Open Enrollment Requested Effective Date of Enrollment ___/___/___	<input type="checkbox"/> Cancellations: Last Date of Employment ___/___/___ Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel listed above – Section B Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached student/dependent max age <input type="checkbox"/> Other (describe) _____
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Product Selection Union Non-union Salaried Hourly Active Retired

DENTAL PLAN: UnitedHealthcare Dental Managed Indemnity
 UnitedHealthcare Dental Options PPO

Dental Benefits provided by United HealthCare Insurance Company

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section D. 3) Please provide your signature and today's date

Signature _____	Date _____	Grp/Subgrp/Bnft Grp
Employer Position _____	Phone Number _____	Plan Variation
		Reporting Code/Branch

Signature (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate to the best of my knowledge and belief.

I understand that the benefit plan that I have selected provides reimbursement for certain costs, which are more fully described in the current Certificate of Coverage .

I understand there may be instances where treatment decisions made by my physician or me or expenses which I have incurred may not be covered by my benefit plan. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law.

I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

Any person who includes any false or misleading information on an applicatin for health care coverage is subject to criminal and civil penalties.

I acknowledge that I have received the "Important Information" and "Statement of Affirmation and Authorization" statements which are included on the back of this form.

Date _____ Employee Signature _____ Spouse Signature _____
(if possible) and applicable
Employer _____

IMPORTANT INFORMATION

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Certificate of Coverage or other materials do not answer your questions. Further information is available at 1-800-896-4830.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your physician's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your physician about these arrangements.
7. We encourage physicians to talk with you about medical care you or your physician think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the medical history, condition or treatment of any person names in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I (we) have not given the agent or any other persons any health information not included on the Request for Dental Coverage. I (we) understand that the insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Dental Coverage and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

Group Insurance provided by or through: United HealthCare Insurance Company

