United Concordia Insurance Company

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 _____

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
  - ☐ 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**
___ ___ ___ ___ ___ ___ ___ ___ ___	Spouse				___	
___ ___ ___ ___ ___ ___ ___ ___ ___	Dependent (A)				___	
___ ___ ___ ___ ___ ___ ___ ___ ___	Dependent (B)				___	
___ ___ ___ ___ ___ ___ ___ ___ ___	Dependent (C)				___	
___ ___ ___ ___ ___ ___ ___ ___ ___	Dependent (D)				___	
___ ___ ___ ___ ___ ___ ___ ___ ___	Other Class of Persons				___	

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) ___/___/_____

Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

_____
Employee Signature — Date

_____
Employer Signature — Phone Number — Date