Dental and Vision Enrollment/Change Form

Group Dental Insurance provided by Dental Benefit Providers of California, Inc. or UNITEDHEALTHCARE INSURANCE COMPANY

Dental Benefit Providers of California, Inc.
3120 W. Lake Center Drive
Santa Ana, CA 92704

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

Group Vision Care Insurance provided by:
UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare®

TO BE COMPLETED BY GROUP

Group Name:		Policy Number:
Group Authorization:	Date of Hire: ___/___/___	Class:
	Plan Variation/Reporting Code:	Plan:
Requested Effective Date of Coverage / Date of Change: ___/___/___		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)

☐ New Group Plan	☐ New Hire	☐ Annual Open Enrollment	☐ Address Change
☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Civil Union(1)
☐ Divorce	☐ Dissolution Of Civil Union	☐ Death	☐ Birth
☐ Adoption/Legal Custody	☐ Court Ordered Dependent	☐ Cobra/State Continuation	
☐ Other:		Start Date ___/___/___ End Date ___/___/___	

Member Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

Number of hours worked per week: _____

MEMBER INFORMATION

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	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 ☐ Domestic Partner(1) ☐ Party to Civil Union(1)		
Primary Care Dentist(3) (First & Last Name): Primary Care Dentist(3) ID:		Existing Patient: ☐ Yes ☐ No	

PRODUCT SELECTION

Person	Dental	Vision
Member	☐ ☐ Waive	☐ ☐ Waive
Spouse (or Domestic Partner(1))	☐ ☐ Waive	☐ ☐ Waive
Dependent	☐ ☐ Waive	☐ ☐ Waive
Family	☐ ☐ Waive	☐ ☐ Waive
	Plan Code:	

FAMILY INFORMATION	Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)				
Check Appropriate Box	Name (Last, First, MI)	Sex / Date of Birth	Relationship[2]	Dentist Name[3] and ID#	Incapacitated[4]
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F ___/___/______	Spouse/ Domestic Partner/ Civil Union	Dentist[3]: ID#: Existing Patient: ☐ Yes ☐ No	N/A
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F ___/___/______	Dependent	Dentist[3]: ID#: Existing Patient: ☐ Yes ☐ No	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F ___/___/______	Dependent	Dentist[3]: ID#: Existing Patient: ☐ Yes ☐ No	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F ___/___/______	Dependent	Dentist[3]: ID#: Existing Patient: ☐ Yes ☐ No	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F ___/___/______	Dependent	Dentist[3]: ID#: Existing Patient: ☐ Yes ☐ No	☐Yes ☐No

IMPORTANT: (1) Domestic Partner or Civil Union coverage is determined by state law or as determined by your Group. Please contact your Group for confirmation. (2) For court ordered Dependent(s), legal documentation must be attached. Please see a Group 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. (3) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (4) Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

AUTHORIZATION AND ACKNOWLEDGEMENT (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.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless it is contained in a written statement signed by me, and a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notice provided below.

FRAUD WARNING NOTICE:
Providing false, incomplete, or misleading information for any policy shall not bar the right to recovery unless the statement was made with actual intent to deceive, or it materially affects the acceptance of the risk or the hazard assumed by the insurers.

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

Member/Enrollee Signature:	Date: / /