Enrollment Form

Group Dental Coverage

Provided by Dental Benefit Providers of California, Inc.

UnitedHealthcare Dental®

| | | | ~~~ | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------|-------------|--------------------|----------------|---------|------------|-----------------------|--------|----------------------------|
| Check the A | ppropriate Boxes | | | | | | | | | |
| | | | | | | | | cel Change | | |
| Reason: New Group Plan | | | | | | | | | | |
| Employee Information | | | | | | | | | | |
| Social Security Number: | | | | Date of Birth: / / | | | | | | |
| Last Name: | | | First Name: | | | | | Middle Initial: | | |
| Address: | | | | | | | | | | |
| City: | State: Zip Code | | | | Code: | | | | | |
| Home Phone: | | Work Phone: | | | Email Address: | | | | | |
| Sex: 🗌 Mal | le 🗌 Female | Marital Status | ☐ Sin | gle | ☐ Ma | arried | ☐ Div | vorced | □ ∨ | Vidowed |
| 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 SM), and Plan Code (e.g., P1211). Plan: Plan Code: | | | | | | | | | | |
| Family Information | | | | | | | | | | |
| | Dependents to be | enrolled, canc | elled, ch | anged | i: (Atta | ch addi | itional sl | neet if ne | cessa | ry) |
| Check | First Name MI L | ast Name (if diff | ferent) | | | | | Relation | shin* | Full-time |
| Appropriate Box | Dependent Soc | cial Security Nur | mber | Da | ate of B | irth | Sex | * | | Student |
| ☐ Enroll ☐ Change ☐ Cancel | | | | | / | | ☐ M ☐ F | ☐ Spo ☐ Dom Pan | nestic | Not Applicable |
| ☐ Enroll ☐ Change ☐ Cancel | | | | 1 | / | | □ M □ F | Depen | dent | ☐ Yes ☐ No School Name: |
| ☐ Enroll☐ Change☐ Cancel | | | | / | /_ | | М F | Depen | dent | ☐ Yes ☐ No School Name: |
| ☐ Enroll ☐ Change ☐ Cancel | | *** | | / | / | | □ M □ F | Depen | dent | ☐ 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 yo under any other dental plan, policy or commedicare? | u, your Spouse (or Domestic entract including another Den | Partner), or any of your tal Benefit Providers of C | Dependents be covered California, Inc. dental plan or | | | | | | |
| Spouse (or Domestic Partner) Name: | Name | Name of other Carrier: | | | | | | | |
| Dependent Name: | Name | Name of other Carrier: | | | | | | | |
| Dependent Name: | Name | Name of other Carrier: | | | | | | | |
| Dependent Name: | Name | of other Carrier: | | | | | | | |
| Primary Dentist Information 🦸 | Please use the Dental Dire | ectory to select a Primary | Care Dentist for yourself and | | | | | | |
| Insured Name: | sured Name: Dentist: | | | | | | | | |
| Spouse (or Domestic Partner*) Name: | Dentist | g Patient Yes No :: g Patient Yes No | ID#: | | | | | | |
| Dependent Name: | Dentist | | ID#: | | | | | | |
| Dependent Name: | Dentist | | ID#: | | | | | | |
| Dependent Name: | Dentist | | ID#: | | | | | | |
| Employee/Applicant Signature (form must be signed) I hereby declare that all the statements | made above are to the boo | t of my knowledge and h | | | | | | | |
| that they are the basis on which insurance | ce requested by me may be i | ssued. | eller, true and complete and | | | | | | |
| I understand that the dental benefit plan fully described in the current Evidence made by my Dentist or me for dental exp | of Coverage. I understand | there may be instances | where treatment decisions | | | | | | |
| The Evidence of Coverage provides den | tal benefits only. Review you | ur Evidence of Coverage | carefully. | | | | | | |
| California Law prohibits an HIV test from botaining health insurance coverage. | oeing required or used by hea | Ith insurance companies : | as a condition of | | | | | | |
| FRAUD WARNING STATEMENT: It is company for the purpose of defrauding the company | a crime to knowingly provide fa ompany. Penalties may include | alse, incomplete, or mislead imprisonment, fines, or a de | ing information to an insurance enial of insurance benefits | | | | | | |
| Employee/Applicant Signature: | | | Date: / / | | | | | | |
| To Be Completed by Employer | | | | | | | | | |
| Employer Name: | | Enrollee Effective Date: / / | Class Code: | | | | | | |
| Enrollment: Date of Hire: New Hire / / Other | Contract Number: | Plan Variation/ Reporting Code: | Plan Code: | | | | | | |
| Employer Authorization: | | | | | | | | | |
| UnitedHealthcare Dental insurance | products are underwritter | n or provided by: De | ntal Benefit Providers of | | | | | | |

400-5267

California, Inc.