



# Dental Enrollment / Change Form

\*Denotes required fields for enrollment. For items with \*\* please select a Reason for Enrollment OR Change.

## A EMPLOYER INFORMATION: To Be Completed By Employer

Company Name: \_\_\_\_\_ \*Group No.: \_\_\_\_\_  
 Date Employed Full Time: \_\_\_\_\_ \*Effective Date of Coverage or Change \_\_\_\_\_

**REASON FOR ENROLLMENT OR CHANGE**

<b>ENROLL</b>		<b>TERMINATE COVERAGE</b>	<b>CHANGE</b>
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Group Request	<input type="checkbox"/> Terminate Subscriber	<input type="checkbox"/> Name
<input type="checkbox"/> New Group	<input type="checkbox"/> Member Request	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Address/Phone
<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Event (Reason)	<input type="checkbox"/> Deceased	
<input type="checkbox"/> COBRA	Date _____ / _____ / _____	<input type="checkbox"/> Termination Reason: _____	
<input type="checkbox"/> Add Dependent	**List Reason: _____		

Employee Status:  Active  COBRA  Salary  Hourly Number of hours a week \_\_\_\_\_  Other \_\_\_\_\_

Benefits Administrator Approval: \_\_\_\_\_ Date: \_\_\_\_\_

## B DENTAL COVERAGE ELECTION

I ELECT THE FOLLOWING FOR MYSELF AND MY DEPENDENT(S):  Dental Plan Code<sup>1</sup> \_\_\_\_\_

Type of Coverage:  Employee  Employee/Spouse  Employee/Child  Employee/Children  Employee/Spouse/Child(ren)

## C DENTAL WAIVER ( only complete if waiving coverage)

I understand that if I decide to apply for dental coverage for myself and any applicable dependents(s) at a later date, neither my dependent(s) nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI.

Waive Dental  Myself  Spouse  Dependent(s) Reason:  Other Insurance  Spousal Coverage

Other Reason (please explain) \_\_\_\_\_

Employee Signature (only if you are waiving coverage) \_\_\_\_\_ Date \_\_\_\_\_

## D EMPLOYEE INFORMATION

\*Last Name \_\_\_\_\_ \*First Name \_\_\_\_\_ MI \_\_\_\_\_

\*Gender  Male  Female \*Birthdate \_\_\_\_\_ \*Social Security Number \_\_\_\_\_

\*Address \_\_\_\_\_

\*City \_\_\_\_\_ \*State \_\_\_\_\_ \*Zip Code \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

## E FAMILY MEMBERS TO BE COVERED OR DELETED

if address and phone numbers of covered dependents are different from those of policyholder, please attach that information on a separate sheet of paper.

	FULL NAME (Last, First, MI)	SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY #
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F	SPOUSE	/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -

## F OTHER DENTAL COVERAGE

WHEN coverage BEGINS, will you or any of your family members have any other dental insurance coverage?  Yes  No

## G EMPLOYEE SIGNATURE

I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application. I hereby agree to the conditions of enrollment below. AUTHORIZATION TO OBTAIN OR RELEASE DENTAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information, as permitted by law, pertaining to dental history or services rendered to Us for any administrative purposes, including evaluation of an application or claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original. I have carefully read this subscription application and agree to the terms specified herein. The foregoing statements are complete, true to the best of my knowledge and belief. For questions call, 1-866-690-4908.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup> Underwritten by Coventry Health and Life Insurance Company 6705 Rockledge Drive, Ste 900 Bethesda, MD 20817  
 DE\_DNT\_MBR\_ENR\_09/08

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

## Misrepresentation

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

**Attention Florida and Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Attention California:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties.

**Attention Colorado Residents:** An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

**Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maryland Residents:** It is a crime to knowingly provide, or to knowingly assist, abet, or conspire with another to provide false, incomplete, or misleading information to an insurance company with intent to injure, defraud, or deceive the company or any other person. Penalties include imprisonment, fines, and denial of insurance benefits.