



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

ENROLL	TERMINATE COVERAGE	CHANGE
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Terminate Subscriber	<input type="checkbox"/> Name
<input type="checkbox"/> New Group	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Address/Phone
<input type="checkbox"/> New Hire	<input type="checkbox"/> Deceased	
<input type="checkbox"/> COBRA	<input type="checkbox"/> Termination Reason: _____	
<input type="checkbox"/> Add Dependent		

Group Request
 Member Request
 Qualifying Event (Reason)
 Date ____ / ____ / ____
 **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 Code¹ _____

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.

Employee Signature _____ Date _____

¹ Underwritten by Coventry Health and Life Insurance Company 6705 Rockledge Drive, Ste 900 Bethesda, MD 20817

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.