UNITED CONCORDIA
America's Premier Dental Insurer

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 _____
- ☐ **DHMO** (Please Specify)
  - ☐ Concordia Plus
  - ☐ 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
  - ☐ Change Provider
  - ☐ 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	8. Provider Number (DHMO Only)
	Spouse/Domestic Partner						
	Dependent (A)						
	Dependent (B)						
	Dependent (C)						
	Dependent (D)						
	Dependent (E)						

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)
			___/___/___

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance 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.

Employee Signature _____ Date _____

Employer Signature _____ Phone Number _____ Date _____

PROGRAM AVAILABILITY

- **Products are not available in any state where prohibited by law or where United Concordia does not have regulatory approval.**
- **Domestic partner coverage is not permitted in Idaho.**

STATE MANDATED PROVISIONS

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

FL: 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.

AZ, GA, KY, NE & NH: All statements made by a Policyholder or by any Insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.

KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

OR: Contestability is limited to two years as stated in the Group Policy.

TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

UT: Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the Rules of (the American Arbitration Association or other recognized arbitrator), a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction.

VA: 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.

UNITED CONCORDIA OPERATES AS A WHOLLY OWNED SUBSIDIARY UNDER THE NAME LISTED BELOW IN THE FOLLOWING STATES:

- United Concordia Dental Corporation of Alabama – AL
- United Concordia Dental Plans, Inc. – MD, NJ
- United Concordia Dental Plans of California, Inc. – CA
- United Concordia Dental Plans of Delaware, Inc. – DE, DC
- United Concordia Dental Plans of Florida, Inc. – FL
- United Concordia Dental Plans of Kentucky, Inc. – KY
- United Concordia Dental Plans of the Midwest, Inc. – MI, MO, OH
- United Concordia Dental Plans of Pennsylvania, Inc. – PA
- United Concordia Dental Plans of Texas, Inc. – TX
- United Concordia Insurance Company – AK, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
- United Concordia Life and Health Insurance Company – DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York – NY