UnitedHealthcare

UnitedHealthcare Dental® Enrollment Form

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)		☐ Enroll ☐ Cancel ☐ Change ☐ Address Change ☐ Name Change Date of Change ____/____/____
LAST NAME	FIRST NAME	MI	ENROLLEE'SDATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER Home ( )	Work ( )		☐ Male ☐ Female ☐ Single ☐ Married
PLAN COVERAGE: ☐ Waive ☐ Employee Only ☐ Employee + Spouse (or Domestic Partner*) ☐ Employee + Child(ren) ☐ Family			
SELECTION TYPE: ☐ High Plan ☐ Low Plan			

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name MiddleInitial LastName (if different)	Date of Birth (Mo/Day/Yr)	Relationship**	If child is over age 19, please indicate status and school:	
		☐ Wife ☐ Husband ☐ Domestic Partner*	☐ Student at ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ M ☐ F ☐ Other Dental Insurance: ______ CARRIER NAME
		☐ Son ☐ Daughter	☐ Student at ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ M ☐ F ☐ Other Dental Insurance: ______ CARRIER NAME
		☐ Son ☐ Daughter	☐ Student at ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ M ☐ F ☐ Other Dental Insurance: ______ CARRIER NAME
		☐ Son ☐ Daughter	☐ Student at ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ M ☐ F ☐ Other Dental Insurance: ______ CARRIER NAME
		☐ Son ☐ Daughter	☐ Student at ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ M ☐ F ☐ Other Dental Insurance: ______ CARRIER NAME

*Domestic Partner coverage is determined by your employer. Please confirm coverage for Domestic Partners with your employer.
**For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.

EMPLOYER INFORMATION – TO BE FILLED OUT BY EMPLOYER

COMPANY NAME: **The Millennium Group**			ENROLLEE EFFECTIVE DATE: (Mo/Day/Yr) ______/______/______	CLASS CODE:
ENROLLMENT: ☐ New Hire ☐ Other	DATE OF HIRE: (Mo/Day/Yr) ____/____/____	POLICY NUMBER: **704734**	PLAN VARIATION/REPORTING CODE:	PLAN CODE: **704734**
EMPLOYER AUTHORIZATION				

I confirm that the information I have provided on this form is complete and accurate.

I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other dental coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

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.

The Certificate provides dental benefits only. Review your Certificate carefully.

SIGNATURE:______________________________ DATE:______________________

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates.