

UNITED CONCORDIA® Dental Enrollment Form

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please select the applicable "Type of Activity" in Section A and provide the identification number and employee name in Section C (also complete Section D for dependent changes).

Fill in circles completely:  Correct  Incorrect

For best results, print in capital letters and avoid contact with edge of box.

Example:

A	B	C
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SECTION A: GENERAL INFORMATION

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 _____

Provider Number (DHMO only)

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2. TYPE OF ACTIVITY

New Enrollment

Cancel Coverage

Cancel All Coverage (Employee & All Dependents)

Cancel Dependent(s) Only

(List dependents to be cancelled in Section D)

Cancel Spouse Only

(List spouse to be cancelled in Section D)

Change (Include Group Number in Section B)

Add Dependent

(e.g., spouse, domestic partner, child, etc.)

Change Address

Reinstate Coverage

Change Group Number

Change Provider

Change Name

To COBRA Group

Other _____

Effective Date (mm/dd/yyyy)

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SECTION B: EMPLOYER USE ONLY

Employer Name

Group Number (9 digits)

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UCCI Payroll Location

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SECTION C: EMPLOYEE INFORMATION—Please print clearly to expedite your request.

Identification Number (Social Security Number)

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Date of Birth (mm/dd/yyyy)

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Gender

Original Employment Date (mm/dd/yyyy)

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First Name

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M.I.

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Last Name

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Home Address

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City

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State

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ZIP Code

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SECTION D: DEPENDENT INFORMATION—Please list the added/cancelled dependents in this section. For more than six dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student 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.

Spouse/Domestic Partner

Identification Number (Social Security Number)

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Date of Birth (mm/dd/yyyy)

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Gender

Provider Number (DHMO only)

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#1

First Name

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M.I.

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Last Name

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Dependent

Identification Number (Social Security Number)

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Date of Birth (mm/dd/yyyy)

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Gender

Provider Number (DHMO only)

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#2

First Name

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M.I.

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Last Name

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Dependent
Identification Number (Social Security Number)

Date of Birth (mm/dd/yyyy)

Gender

Provider Number (DHMO only)

#3

First Name

M.I.

Last Name

Dependent
Identification Number (Social Security Number)

Date of Birth (mm/dd/yyyy)

Gender

Provider Number (DHMO only)

#4

First Name

M.I.

Last Name

Dependent
Identification Number (Social Security Number)

Date of Birth (mm/dd/yyyy)

Gender

Provider Number (DHMO only)

#5

First Name

M.I.

Last Name

Dependent
Identification Number (Social Security Number)

Date of Birth (mm/dd/yyyy)

Gender

Provider Number (DHMO only)

#6

First Name

M.I.

Last Name

SECTION E: 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.

Policyholder Name (First, M.I., Last)

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

Phone Number

Email Address

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.—DC, MD, NJ
- United Concordia Dental Plans of California, Inc.—CA
- 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, HI, 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

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366 (TTY: 711) まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید.