

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 <input type="checkbox"/> FFS (Indemnity, Active PPO, Passive PPO - Please Specify) <input type="checkbox"/> Concordia Access <input type="checkbox"/> Concordia Choice <input type="checkbox"/> Concordia Flex <input type="checkbox"/> Concordia Preferred <input type="checkbox"/> Concordia Select <input type="checkbox"/> Other _____ <input type="checkbox"/> DHMO (Please Specify) <input type="checkbox"/> Concordia Plus <input type="checkbox"/> Other _____	2. TYPE OF ACTIVITY <input type="checkbox"/> New Enrollment <input type="checkbox"/> Cancel Coverage (Cancel All Coverage (Employee & All Dependents) Cancel Dependent(s) Only (List dependents to be cancelled) <input type="checkbox"/> Change (Please Specify) <input type="checkbox"/> Add Dependent (e.g., spouse, domestic partner, child, etc.) <input type="checkbox"/> Change Address <input type="checkbox"/> Reinstate Coverage <input type="checkbox"/> Change Name <input type="checkbox"/> Change Group Number <input type="checkbox"/> Change Provider <input type="checkbox"/> COBRA <input type="checkbox"/> 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) ____/____/____
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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 _____