Dental and Vision Enrollment/Change Form

cbgCONFIDENT

Group Dental Insurance and Vision Care Insurance provided by:
UNITEDHEALTHCARE INSURANCE COMPANY
Fax completed form to: 612-825-8392
CONFIDENT speters@capital-benefits.com

UnitedHealthcare®

TO BE COMPLETED BY GROUP

Group Name: Northwest Reading Clinic 19420		Policy Number:
Group Authorization:	Date of Hire: ___/___/___	Class:
	Plan Variation/Reporting Code:	Plan:
Requested Effective Date of Coverage / Date of Change: ___/___/___		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)

☐ New Group Plan	☐ New Hire	☐ Annual Open Enrollment	☐ Address Change
☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Civil Union(1)
☐ Divorce	☐ Dissolution Of Civil Union	☐ Death	☐ Birth
☐ Adoption/Legal Custody	☐ Court Ordered Dependent	☐ Cobra/State Continuation	
☐ Other:		Start Date ___/___/___ End Date ___/___/___	

Member Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

Number of hours worked per week: _____

MEMBER INFORMATION

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of Birth: / /		
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:		Email Address:
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner(1) ☐ Party to Civil Union(1)		
Primary Care Dentist(3) (First & Last Name): Primary Care Dentist(3) ID:			Existing Patient: ☐ Yes ☐ No

PRODUCT SELECTION

Person	Dental	Vision
Member	☐	☐
Spouse (or Domestic Partner(1))	☐	☐
Dependent	☐	☐
Waiving	☐	☐
	Plan Code:	

FAMILY INFORMATION

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	Name (Last, First, MI)	Birth Date	Sex	Relationship(2)	Dentist Name (3) and ID#	Incapacitated(4)
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Spouse/ Domestic Partner/ Civil Union	Dentist(3): ID#: Existing Patient: ☐ Yes ☐ No	N/A
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	Dentist(3): ID#: Existing Patient: ☐ Yes ☐ No	☐ Yes ☐ No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	Dentist(3): ID#: Existing Patient: ☐ Yes ☐ No	☐ Yes ☐ No

Check Appropriate Box	Name (Last, First, MI)	Birth Date	Sex	Relationship(2)	Dentist Name (3) and ID#	Incapacitated(4)
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	Dentist(3): ID#: Existing Patient ☐ Yes ☐ No	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	Dentist(3): ID#: Existing Patient ☐ Yes ☐ No	☐Yes ☐No

IMPORTANT: (1) Domestic Partner or Civil Union coverage is determined by state law or as determined by your Group. Please contact your Group for confirmation. (2) For court ordered Dependent(s), legal documentation must be attached. Please see a Group representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet. (3) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (4) Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

AUTHORIZATION AND ACKNOWLEDGEMENT
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless it is contained in a written statement signed by me, and a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

FRAUD WARNING NOTICES: (Please review the notice that applies in your state.)

For residents of Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For residents of District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For residents of Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For residents of Kentucky:
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 may commit a fraudulent insurance act, which is a crime.

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

For residents of New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico:
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 AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio:
Any person who, with 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 is guilty of insurance fraud.

For residents of Oklahoma:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

For residents of the state of Pennsylvania:
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.

For residents of Vermont:
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 may be guilty of a crime.

For residents of Virginia:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may have violated state law.

For residents of Washington:
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.

For residents of all other states:
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.

For residents of Florida:
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.

Member/Enrollee Signature:	Date: / /