

Dental Enrollment Form

Group Dental Coverage Provided by
United HealthCare Insurance Company



SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change <input type="checkbox"/> Waiver	
		DATE : / /	
LAST NAME		FIRST NAME	
		MI	
ADDRESS		CITY	STATE ZIP
TELEPHONE NUMBER		<input type="checkbox"/> Male <input type="checkbox"/> Female	
HOME ()		WORK ()	
		<input type="checkbox"/> Single <input type="checkbox"/> Married	
APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME		

Dental Enrollment

Effective Date: / /

TRADITIONAL PLAN	<input type="checkbox"/> Benchmark <input type="checkbox"/> Open Choice <input type="checkbox"/> Incentive <input type="checkbox"/> Opportunity				
PACKAGE PLAN	<input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C	<input type="checkbox"/> IMMEDIATE COVERAGE PLAN			
PLAN COVERAGE	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family				

Vision Enrollment - Add Optional MWG Vision Coverage Add Vision Coverage

PLAN COVERAGE	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Family
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INFORMATION FOR DEPENDENT COVERAGE

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

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship			If Child is over 19, please indicate status and school	
		<input type="checkbox"/> Wife	<input type="checkbox"/> Husband	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel

*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.

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION
EFFECTIVE DATE
TYPE OF COVERAGE

SIGNATURE _____
I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement

MINIMUM ENROLLMENT IS FOR ONE YEAR

Unimerica Dental Indemnity Plan is underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York), United HealthCare Insurance Company of New York; Hauppauge, New York (New York Only).