

Dental Enrollment Form

Group Dental Coverage

CONFIDENTSM
 Provided by
 United HealthCare Insurance Company by cbg

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
		DATE : / /	
LAST NAME	FIRST NAME	MI	
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	HOME ()	WORK ()	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married
APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME		
PLAN COVERAGE <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse (or Domestic Partner) <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family			

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"/> Domestic Partner <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

CONFIDENTSM by cbg Dental PPO Plans are 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).

Terms of eSignature:

Providing your Name, Social Security Number and checking the box below is the same as providing your signature on a hard copy document. By checking the box below you certify that:

- The information provided in the Application is true, accurate and complete.***
- You have read, or have had read to you, the completed Application and understand that any false statement or misrepresentation made in it may result in a loss of coverage.***

I have read and agreed to the terms of eSignature

In order to "SUBMIT" you must read and agree to the terms of eSignature