

United Concordia Insurance Company

DENTAL ENROLLMENT FORM

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 _____	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"/> 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. Gender _____	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. Gender	7. Date of Birth
_____	Spouse	_____	_____	_____	_____	_____
_____	Dependent (A)	_____	_____	_____	_____	_____
_____	Dependent (B)	_____	_____	_____	_____	_____
_____	Dependent (C)	_____	_____	_____	_____	_____
_____	Dependent (D)	_____	_____	_____	_____	_____
_____	Other Class of Persons	_____	_____	_____	_____	_____

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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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.

Employee Signature _____ Date _____

Employer Signature _____ Phone Number _____ Date _____

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 u 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.