GROUP ENROLLMENT/CHANGE REPORT

UNITED CONCORDIA

Group Information -- to be completed by Employer:

United Concordia Life and Health Insurance Company United Concordia Dental Plans, Inc.	Group Name:	Group Number:	Class Code:

A. Type of Activity - to be completed by Employer. *Refer to instructions before completing this form. Print clearly.*

	Activity - Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change:
1. ADD	☐ Enrollment of a new Enrollee/Subscriber ☐ Add Spouse/Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	Date of Hire: _____/_____/_____ _____ _____ _____
2. REMOVE	☐ Employee Withdrawal/Termination ☐ Remove Spouse/Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other ☐ Add/Change Office ID Numbers: Dentist	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: _____/_____/_____
  - Qualifying Event #: _____**
  - Date of Qualifying Event: _____/_____/_____

Billing: ☐ Group ☐ Home (Section B)

**Attach proof of disability*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: _____/_____/_____
- Qualifying Event #: _____**
- Date of Qualifying Event: _____/_____/_____

Billing: ☐ Group ☐ Home (what address?)
- ☐ Section B *OR*
- ☐ Section E

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ For Dependent
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: _____/_____/_____
  - Qualifying Event #: _____**
  - Date: _____/_____/_____

Billing: ☐ Group ☐ Home (what address?)
- ☐ Section B *OR*
- ☐ Section F

***Qualifying event #s: see list in Instructions.*

B. Employee Information - to be completed by the Employee

Name (Last, First, MI):

SSN:

Home

Street/Apt: _____
Street/Apt: _____
City: _____ State: _____ Zip Code: _____

Birthdate (mm/dd/yyyy):

☐ Male ☐ Female

Phone: (_____)_____
Email: _____

Work

Employer Name: _____
Street/Apt: _____
City: _____ State: _____ Zip Code: _____

Phone: (_____)_____
Email: _____
Employment Date: _____/_____/_____
Hours worked per week: _____

Activity

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

Dentist LOC#:_____ NPI#: _____ Current Patient: ☐ Yes ☐ No
Address:_____ Zip+4 _____

Other Health Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy#: _____
Medicare ID#, if any: _____

Previous Coverage? ☐ Yes ☐ No
If Yes:
Effective date: _____/_____/_____ Termination Date: _____/_____/_____

Payer Name: _____
Policy #:_____
Submit a Certificate of Creditable Coverage

C. Plan Option - to be completed by the Employee. *Check one FFS:* ☐ Concordia Access ☐ Concordia Choice ☐ Concordia Flex ☐ Concordia Select ☐ Other _____
DHMO: ☐ Concordia Plus ☐ Other _____

D. Other Individuals Covered - to be completed by the Employee. *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof if full-time post-secondary student. Attach proof of disability.*

1. Spouse; Domestic or Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L: _____ F: _____ MI:_____	Name (last, first, MI) L: _____ F: _____ MI:_____	Name (last, first, MI) L: _____ F: _____ MI:_____	Name (last, first, MI) L: _____ F: _____ MI:_____
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):

☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ____________________ Policy #: ____________________ Medicare ID#: ____________________	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ____________________ Policy #: ____________________ Medicare ID#: ____________________	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ____________________ Policy #: ____________________ Medicare ID#: ____________________	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ____________________ Policy #: ____________________ Medicare ID#: ____________________
Previous Coverage: ☐Yes ☐ No *If yes:* Effective: _____/_____/_____ Termination: _____/_____/_____ Payer Name: ____________________ Policy #: ____________________ Submit a copy of the Certificate of Creditable Coverage	Previous Coverage: ☐Yes ☐ No *If yes:* Effective: _____/_____/_____ Termination: _____/_____/_____ Payer Name: ____________________ Policy #: ____________________ Submit a copy of the Certificate of Creditable Coverage	Previous Coverage: ☐Yes ☐ No *If yes:* Effective: _____/_____/_____ Termination: _____/_____/_____ Payer Name: ____________________ Policy #: ____________________ Submit a copy of the Certificate of Creditable Coverage	Previous Coverage: ☐Yes ☐ No *If yes:* Effective: _____/_____/_____ Termination: _____/_____/_____ Payer Name: ____________________ Policy #: ____________________ Submit a copy of the Certificate of Creditable Coverage
Dentist Office NPI#: ____________________ Address: ____________________ ____________________ ____________Zip+4__________ Current Patient? ☐ Yes ☐ No	Dentist Office NPI#: ____________________ Address: ____________________ ____________________ ____________Zip+4__________ Current Patient? ☐ Yes ☐ No	Dentist Office NPI#: ____________________ Address: ____________________ ____________________ ____________Zip+4__________ Current Patient? ☐ Yes ☐ No	Dentist Office NPI#: ____________________ Address: ____________________ ____________________ ____________Zip+4__________ Current Patient? ☐ Yes ☐ No
Employed? ☐ Yes ☐ No *If yes, complete Section E1*	If last name is different from Employee's, please explain: ____________________ ____________________	If last name is different from Employee's, please explain: ____________________ ____________________	If last name is different from Employee's, please explain: ____________________ ____________________
Home or billing address same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/ Domestic Partner Information - to be completed by Employee. *If not applicable, please mark as "N/A."*

1. Employer Name: _____
Employer Address: _____
City, State, Zip Code: _____
Employer Phone: (_____) _____

2a.
Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____

2b. Please explain why the address is different:
_____
_____
_____

F. Additional Child Information - to be completed by Employee. *Provide information below about children listed in Section D, **if** they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s): _____
Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____
Reason: _____

Name(s): _____
Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____
Reason: _____

G. Race/Ethnicity - to be completed by the Employee, at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: _____

I. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: _____ Date: _____

Representative's Title: _____

The fields in the PDF version of this form can be completed electronically using Adobe Acrobat Reader software.
Use the "Submit" button to email the completed form to United Concordia,
or use the "Print" button to print the completed form for your records and mail or fax it.

Print Form

INSTRUCTIONS

Employers - You must complete the Employer Group Information and sections A and I in order for this application to be processed.

Employees - You must complete sections B through I.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You must also obtain each provider's NPI number at *www.ucci.com* or by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 26

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in martial status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT -- APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give United Concordia Life and Health Insurance Company or United Concordia Dental Plans, Inc., or any consumer reporting agency acting on behalf of United Concordia Life and Health Insurance Company or United Concordia Dental Plans, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that United Concordia Life and Health Insurance Company or United Concordia Dental Plans, Inc. has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree United Concordia Life and Health Insurance Company or United Concordia Dental Plans, Inc. will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorized my Employer to withhold payments from my wages as contribution to the premium, as appropriate.