3831

UNITED CONCORDIA® Dental Enrollment Form

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please select the applicable "Type of Activity" in Section A and provide the identification number and employee name in Section C (also complete Section D for dependent changes).

Fill in circles completely: Correct ● Incorrect ⊗

For best results, print in capital letters and avoid contact with edge of box.

Example: A B C

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

- ○ **FFS—Indemnity, Active PPO, Passive PPO** (Please specify)
  - ○ Concordia Access
  - ○ Concordia Choice
  - ○ Concordia Flex
  - ○ Concordia Preferred
  - ○ Concordia Select
  - ○ Other
- ○ **DHMO** (Please specify)
  - ○ Concordia Plus
  - ○ Other

Provider Number (DHMO only)

2. TYPE OF ACTIVITY

- ○ **New Enrollment**
- ○ **Cancel Coverage**
  - ○ Cancel All Coverage (Employee & All Dependents)
  - ○ Cancel Dependent(s) Only (List dependents to be cancelled in Section D)
  - ○ Cancel Spouse Only (List spouse to be cancelled in Section D)
- ○ **Change (Include Group Number in Section B)**
  - ○ Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - ○ Change Address
  - ○ Reinstate Coverage
  - ○ Change Group Number
  - ○ Change Provider
  - ○ Change Name
  - ○ To COBRA Group
  - ○ Other

Effective Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

SECTION B: EMPLOYER USE ONLY

Employer Name

Group Number (9 digits)

UCCI Payroll Location

SECTION C: EMPLOYEE INFORMATION—Please print clearly to expedite your request.

Identification Number (Social Security Number)

Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Gender

Original Employment Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

First Name **M.I.** **Last Name**

Home Address

City **State** **ZIP Code**

SECTION D: DEPENDENT INFORMATION—Please list the added/cancelled dependents in this section. For more than six dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student 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

Spouse/Domestic Partner
Identification Number (Social Security Number)

Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Gender

Provider Number (DHMO only)

First Name **M.I.** **Last Name**

#2

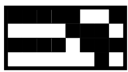
Dependent
Identification Number (Social Security Number)

Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Gender

Provider Number (DHMO only)

First Name **M.I.** **Last Name**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#3
Dependent
Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#4
Dependent
Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#5
Dependent
Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#6
Dependent
Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

SECTION E: 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.

Policyholder Name (First, M.I., Last)	**Insurance Company**
Policy/Identification Number	**Effective Date** (mm/dd/yyyy) / /

I represent that all information supplied in this application is true and correct. 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, commits a fraudulent insurance act, which is a crime.

Employee Signature | **Phone Number** | **Email Address** | **Date**

Employer Signature | **Phone Number** | **Date**

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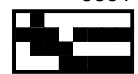

Program Availability

- Products are not available in any state where prohibited by law or where United Concordia does not have regulatory approval.
- Domestic partner coverage is not permitted in Idaho.

State Mandated Provisions

CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FL: 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.

AZ, GA, KY, NE & NH: All statements made by a Policyholder or by any Insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.

KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

LA: 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.

NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

OR: Contestability is limited to two years as stated in the Group Policy.

TN: 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.

UT: Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the Rules of (the American Arbitration Association or other recognized arbitrator), a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction.

VA: 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.

United Concordia operates as a wholly owned subsidiary under the name listed below in the following states:

- United Concordia Dental Corporation of Alabama—AL
- United Concordia Dental Plans, Inc.—DC, MD, NJ
- United Concordia Dental Plans of California, Inc.—CA
- United Concordia Dental Plans of Florida, Inc.—FL
- United Concordia Dental Plans of Kentucky, Inc.—KY
- United Concordia Dental Plans of the Midwest, Inc.—MI, MO, OH
- United Concordia Dental Plans of Pennsylvania, Inc.—PA
- United Concordia Dental Plans of Texas, Inc.—TX
- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY

UNITED CONCORDIA
Insuring America's Dental Health

United Concordia would like to make it as easy as possible to use and understand your dental benefits. To help us do that, please complete the preference form located on the back and return with your completed enrollment form if you have not already provided us this information. All information will be kept confidential and is not a requirement in order to receive dental benefits.

United Concordia quiere facilitarle lo más posible la comprensión y la utilización de sus beneficios dentales. Para ayudarnos a lograrlo, llene el formulario de preferencia que aparece al reverso y envíelo con su formulario de inscripción completado si todavía no nos ha proporcionado esta información. Toda la información se mantendrá confidencial y no es un requisito para poder recibir beneficios dentales.

UNITED CONCORDIA
Insuring America's Dental Health

Employee ID Number, i.e. Social Security Number (Numero de identificación del empleado, es decir, número del Seguro Social)	___ – __ – ____

	Covered Member A (Afiliado cubierto A) Name ________________ (Nombre)	Covered Member B (Afiliado cubierto B) Name ________________ (Nombre)	Covered Member C (Afiliado cubierto C) Name ________________ (Nombre)	Covered Member D (Afiliado cubierto D) Name ________________ (Nombre)
Spoken language preference (Idioma **hablado** de preferencia)	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________
Written language preference (Idioma **escrito** de preferencia)	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________	☐ English (Inglés) ☐ Spanish (Español) ☐ Chinese (Chino) ☐ Korean (Coreano) ☐ Tagalog (Tagalo) ☐ Vietnamese (Vietnamita) ☐ Declined to state (Prefiere no declararlo) ☐ Other, please specify (Otro, por favor especificar) ________________
Choose one to best represent the covered member (Elija uno que represente mejor al afiliado cubierto)	☐ American Indian/Alaska native (Indígena americano/Indígena de Alaska) ☐ Asian (Asiático) ☐ Black/African American (Negro/Afroamericano) ☐ Native Hawaiian/Pacific Islander (Indígena hawaiano/Oriundo de las Islas del Pacifico) ☐ White/Caucasian (Blanco/Caucásico) ☐ Other, please specify (Otro, por favor especificar) ________________ ☐ Declined to state (Prefiere no declararlo)	☐ American Indian/Alaska native (Indígena americano/Indígena de Alaska) ☐ Asian (Asiático) ☐ Black/African American (Negro/Afroamericano) ☐ Native Hawaiian/Pacific Islander (Indígena hawaiano/Oriundo de las Islas del Pacifico) ☐ White/Caucasian (Blanco/Caucásico) ☐ Other, please specify (Otro, por favor especificar) ________________ ☐ Declined to state (Prefiere no declararlo)	☐ American Indian/Alaska native (Indígena americano/Indígena de Alaska) ☐ Asian (Asiático) ☐ Black/African American (Negro/Afroamericano) ☐ Native Hawaiian/Pacific Islander (Indígena hawaiano/Oriundo de las Islas del Pacifico) ☐ White/Caucasian (Blanco/Caucásico) ☐ Other, please specify (Otro, por favor especificar) ________________ ☐ Declined to state (Prefiere no declararlo)	☐ American Indian/Alaska native (Indígena americano/Indígena de Alaska) ☐ Asian (Asiático) ☐ Black/African American (Negro/Afroamericano) ☐ Native Hawaiian/Pacific Islander (Indígena hawaiano/Oriundo de las Islas del Pacifico) ☐ White/Caucasian (Blanco/Caucásico) ☐ Other, please specify (Otro, por favor especificar) ________________ ☐ Declined to state (Prefiere no declararlo)
Choose one to best represent the covered member (Elija uno que represente mejor al afiliado cubierto)	☐ Hispanic/Latino (Hispano/Latino) ☐ Non-Hispanic/Non-Latino (No Hispano/No Latino) ☐ Declined to state (Prefiere no declararlo)	☐ Hispanic/Latino (Hispano/Latino) ☐ Non-Hispanic/Non-Latino (No Hispano/No Latino) ☐ Declined to state (Prefiere no declararlo)	☐ Hispanic/Latino (Hispano/Latino) ☐ Non-Hispanic/Non-Latino (No Hispano/No Latino) ☐ Declined to state (Prefiere no declararlo)	☐ Hispanic/Latino (Hispano/Latino) ☐ Non-Hispanic/Non-Latino (No Hispano/No Latino) ☐ Declined to state (Prefiere no declararlo)

Please attach an additional form if you have more than 4 family members.
(Adjunte un formulario adicional si tiene más de 4 familiares).

TO SUBMIT **(PARA ENVIAR)**	**Mail:** **(Correo)**	United Concordia Membership Services DP2 4401 Deer Path Rd Harrisburg, PA 17109	**Fax:** **(Fax)**	1-800-329-9093

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently based on race, color, national origin, ancestry, age, religion, disability, marital status, gender, sex assigned at birth, sexual orientation, sex stereotypes, 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, call 1-800-332-0366 (TTY: 711) for assistance or 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, ancestry, age, religion, disability, marital status, gender, sex assigned at birth, sexual orientation, sex stereotypes, gender identity or recorded gender, you can file a complaint 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 complaint in person or by mail, fax, or email. If you need help filing a complaint, the Civil Rights Coordinator is available to help you. You can also file a complaint with the California Department of Insurance electronically through the Consumer Complaint Center, available at http://www.insurance.ca.gov/01-consumers/101-help/index.cfm, or by mail or phone at:

California Department of Insurance
Consumer Services Division
300 S. Spring Street
Los Angeles, CA 90013
1-800-927-4357

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

Language	Tagline
English	ATTENTION: If you speak English, you have the right to language assistance services at no charge to you, including interpretation services and translated written documents in your preferred language. Call 1-800-332-0366 (TTY: 711) for assistance.
Español (Spanish)	ATENCIÓN: Si habla español, tiene derecho a servicios de asistencia lingüística sin coste alguno, incluidos servicios de interpretación y traducciones de documentos escritos en la lengua que desee. Llame al 1-800-332-0366 (TTY: 711) para más información.
繁體中文 (Chinese)	注意：如果您的語言是繁體中文，您有權免費使用語言協助服務，包括以您偏好的語言提供的口譯服務和翻譯的書面文件。如需協助，請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	LƯU Ý: Nếu quý vị nói Tiếng Việt, bạn sẽ có quyền hưởng miễn phí dịch vụ hỗ trợ ngôn ngữ, bao gồm dịch vụ phiên dịch và tài liệu bằng văn bản được dịch sang ngôn ngữ bạn chọn. Gọi điện đến số 1-800-332-0366 (TTY: 711) để được hỗ trợ.
Tagalog (Tagalog)	PANSININ: Kung nagsasalita ka ng Tagalog, may karapatan ka sa mga serbisyong tulong sa wika nang wala kang babayaran, kabilang ang mga serbisyo sa pagsasalin at mga nakasulat na dokumento na naisalin sa iyong pinipiling wika. Tumawag sa 1-800-332-0366 (TTY: 711) para sa tulong.
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 원하는 언어로의 번역 서비스 및 번역된 서면 문서를 포함하여, 언어 지원 서비스를 무료로 사용할 수 있습니다. 도움이 필요하면 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Հայերեն (Armenian)	ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Դուք հայերեն եք խոսում, Դուք իրավունք ունեք անվճար ստանալ լեզվական աջակցության ծառայություններ, այդ թվում նաև՝ բանավոր թարգմանության և փաստաթղթերի գրավոր թարգմանության ծառայություններ՝ Ձեր նախընտրած լեզվով: Օգնություն ստանալու համար զանգահարեք 1-800-332-0366 (TTY՝ 711) հեռախոսահամարով:
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، حق دارید از خدمات تسهیلات زبانی بصورت رایگان استفاده کنید، از جمله خدمات ترجمه شفاهی و اسناد کتبی ترجمه شده به زبان انتخابی خودتان. با 1-800-332-0366 (تله تایپ: 711) تماس بگیرید
Русский (Russian)	ВНИМАНИЕ: Пользователям, разговаривающим на русском языке, бесплатно предоставляются службы языковой поддержки, включая услуги устного перевода и письменного перевода документов на предпочитаемый язык. Тел. службы поддержки 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。サービスには、選択された言語による通訳や文書の翻訳も含まれます。サポートが必要な場合は、1-800-332-0366 (TTY: 711)まで、お電話にてご連絡ください。
العربية (Arabic)	تنبيه: إذا كنت تتحدث العربية، لديك الحق في الحصول على خدمات المساعدة اللغوية مجانًا، بما في ذلك خدمات الترجمة والمستندات المكتوبة المترجمة بلغتك المفضلة. اتصل على الرقم 0366-332-800-1 (خدمة الرسائل النصية: 711) للحصول على المساعدة.
ਪੰਜਾਬੀ (Punjabi)	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਲੈਣ ਦਾ ਹੱਕ ਹੈ, ਜਿਸ ਵਿੱਚ ਤੁਹਾਡੀ ਪਸੰਦ ਦੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਅਤੇ ਅਨੁਵਾਦ ਕੀਤੇ ਗਏ ਲਿਖੇ ਹੋਏ ਦਸਤਾਵੇਜ਼ ਸ਼ਾਮਲ ਹਨ। ਸਹਾਇਤਾ ਲਈ 1-800-332-0366 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
កម្ពុជា (Cambodian)	ប្រការត្រូវចងចាំ៖ ប្រសិនបើលោកអ្នកនិយាយភាសាអង់គ្លេស លោកអ្នកមានសិទ្ធិទទួលបានជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នកដោយរួមបញ្ចូលទាំងសេវាកម្មបកប្រែផ្ទាល់មាត់ និងឯកសារដែលបានបកប្រែជាលាយលក្ខណ៍អក្សរជាភាសាដែលលោកអ្នកពេញចិត្ត។ សូមហៅមកកាន់លេខ 1-800-332-0366 (TTY: 711) ដើម្បីទទួលបានជំនួយ។
ຊິນເຜົ່າລາວສູງ (Hmong)	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາມົ້ງ, ທ່ານມີສິດໄດ້ຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍລວມມີການບໍລິການລ່າມແປພາສາ ແລະ ການແປເອກະສານເປັນລາຍລັກອັກສອນເປັນພາສາທີ່ທ່ານເລືອກ. ກະລຸນາໂທຫາເບີ 1-800-332-0366 (TTY: 711) ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ.
हिंदी (Hindi)	ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपको बिना किसी शुल्क के भाषा में सहायता संबंधित सेवाएँ प्राप्त करने का अधिकार है, जिसमें शामिल हैं इंटरप्रेटर की सेवाएँ और आपकी पसंदीदा भाषा में अनुवादित लिखित दस्तावेज़. सहायता के लिए 1-800-332-0366 (TTY: 711) पर कॉल करें.
ไทย (Thai)	โปรดทราบ หากภาษาพูดของคุณคือภาษาอังกฤษ คุณมีสิทธิที่จะได้รับความช่วยเหลือทางด้านภาษาโดยไม่มีค่าใช้จ่ายใด ๆ รวมถึงการบริการด้านล่ามและการแปลเอกสารที่แปลเป็นภาษาที่คุณต้องการ หากต้องการความช่วยเหลือ กรุณาติดต่อ 1-800-332-0366 (TTY: 711)