UNITED CONCORDIA

America's Premier Dental Insurer

ENROLLMENT FORM

For New Enrollment, please complete all sections of this form. If you are enrolling for employee-only coverage, you do not need to fill in the Dependent Information section. For Enrollment Changes, please complete the type of Activity and Only the applicable changes along with the employee name and ID number.

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

- ☐ **FFS** (Indemnity, Active, Passive, PPO - Please Specify)
  - ☐ Concordia Choice
  - ☐ Concordia Flex
  - ☐ Concordia Preferred* (see reverse)
  - ☐ Concordia Select
  - ☐ Other
- ☐ **DHMO** (Please Specify)
  - ☐ Concordia Plus** (see reverse)
  - ☐ Third Column** (see reverse)
  - ☐ Other

2. TYPE OF ACTIVITY

- ☐ **New Enrollment**
- ☐ **Change** (Please Specify)
  - ☐ Add Dependent
  - ☐ Cancel All Coverage (Enrollee & All Dependents)
  - ☐ Cancel Dependent(s) Only
  - ☐ Change Address
  - ☐ Change of Employee Status (Type Contract Change)
  - ☐ Reinstate Coverage
  - ☐ Change Name
  - ☐ Change Provider
  - ☐ Other

3. GROUP INFORMATION

Group Name

Group Number ☐☐☐☐☐☐ **Sub Group** ☐☐☐

Payroll Location ☐☐☐☐☐ **Group Location**

Effective Date (Example: May 1, 2002 – 05012002) ☐☐☐☐☐☐☐☐

SECTION B: EMPLOYEE INFORMATION

1. Contract ID Number	2. Original Employment (Date Example May 1, 2002 - 05012002) ☐☐☐☐☐☐☐☐		
3. Employee Name (Last, First, Middle Initial)	4. Date of Birth	5. Sex	6. Provider Number
7. Home Address	City	State	Zip Code

8. Employee Status: ☐ Hourly ☐ Salaried (Union Represented) ☐ Management ☐ Salaried (Non-Union Represented) ☐ Retired

SECTION C: DEPENDENT INFORMATION

(If dependent children listed below are handicapped or full-time students age 19 or over, please see your group administer for a dependent certification form, complete and attach the form to this application.)

1. Contract ID Number	2. Type	3. Last Name	4. First Name	5. MI	6. Sex	7. Date of Birth	8. Provider Number
	Spouse						
	Dependent (A)						
	Dependent (B)						
	Dependent (C)						

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 Date

Employer Signature Phone Number Date

5000 (07/02) ® GCIU

*PLEASE SEE REVERSE SIDE FOR PROGRAM AVAILABILITY