Enrollment Form

Group Dental Coverage and
Group Vision Care Insurance
Provided by United HealthCare Insurance Company of New York

[UnitedHealthcare Dental®]

[SPECTERA A UnitedHealth Group Company]

Check the Appropriate Boxes

Requested Effective Date of Coverage / Date of Change: / / ☐ Enroll ☐ Cancel ☐ Change

Reason: ☐ New Group Plan ☐ New Hire ☐ Annual Open Enrollment ☐ Address Change ☐ Name Change ☐ Employee Terminated ☐ Marriage ☐ Divorce ☐ Death ☐ Birth ☐ Adoption/Legal Custody ☐ Court ordered Dependent ☐ Dependent married/reached age limit ☐ Cobra/State Continuation ☐ Other:

Employee Information

Social Security Number: - -	Date of Birth: / /	
Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:
Sex: ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Product Selection

Plan Coverage: ☐ Employee Only ☐ Employee + Spouse (or Domestic Partner*) ☐ Employee + Child(ren) ☐ Family

Person	Dental	Vision	If your Employer offers you a choice of dental plan, please indicate your Plan selection (e.g., Options PPO, Indemnity, INO℠), and Plan Code (e.g., P1211).
Employee	☐	☐	
Spouse (or Domestic Partner*)	☐	☐	
Dependent	☐	☐	Plan: Plan Code:

Family Information

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name / MI / Last Name (if different) / Dependent Social Security Number	Date of Birth	Sex	Relationship**	Full-time Student
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer

.**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

DV-ENROLL-ER-NY (10/2006)

Other Dental Coverage Information

On the day this coverage begins, will you, your spouse (or domestic partner*), or any of your dependents be covered under any other dental or vision plan or policy including another United HealthCare Insurance Company dental or vision plan or Medicare?
☐ Yes ☐ No

Spouse (or Domestic Partner*) Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer.

Employee/Applicant Signature
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I understand that the dental and/or vision benefit plan I have selected provides reimbursement for certain dental and/or vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for dental and/or vision expenses which I have incurred may not be covered by my dental and/or vision benefit plan.

The Certificates provide dental and/or vision benefits only. Review your Certificates carefully.

FRAUD WARNING NOTICE:
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.

Employee/Applicant Signature:	Date: / /

To Be Completed by Employer

Employer Name:			Enrollee Effective Date: / /	Class Code:
Enrollment: ☐ New Hire ☐ Other	Date of Hire: / /	Policy Number:	Plan Variation/ Reporting Code:	Plan Code:
Employer Authorization:				

[UnitedHealthcare Dental] and [Spectera] vision insurance products are underwritten or provided by: United HealthCare Insurance Company of New York, Hauppauge, NY.