PREMIER ACCESS
Dental and Vision

EMPLOYEE ENROLLMENT/CHANGE FORM

Use this form for a new enrollment or a change to an existing enrollment. Please complete in blue or black ink.
Mail to: Premier Access Membership Accounting, P.O. Box 659020, Sacramento, CA 95865-9020 or fax to: 877.648.7748

Group Number:_____ Coverage Type: ❑ PPO ❑ DHMO

Effective Date of Enrollment/Change:_____

Reason for Enrollment Form

❑ New Enrollment/New Hire
- ❑ Qualifying Event *(Attach supporting documentation)*
- ❑ Late Enrollee *(Subject to Late Enrollee Waiting Period)*

❑ Add Dependent (including spouse and registered domestic partner)
Qualifying Event: _____
Date of Qualifying Event: _____

❑ Change of Address
❑ Terminate Dental Coverage, Subscriber & Dependent(s)
❑ Terminate Dental Coverage, Dependent(s) Only
❑ Change in Other Dental Insurance *(Please see reverse side)*
❑ Other (*Specify:* _____)

Subscriber (Employee) Information

Social Security Number: _____ Date of Hire: _____
Last Name: _____ First Name: _____ MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ E-mail Address: _____
Date of Birth: _____ Sex: ❑ M ❑ F Married? ❑ Yes ❑ No Children? ❑ Yes ❑ No
Employer (Company) Name: _____
Job Title: _____ Division/Class: _____ Hours Worked Per Week: _____
Preferred Spoken Language: _____ Preferred Written Language: _____
Ethnicity (optional): _____ Race (optional): _____

Managed Care Only: Please select a Primary Care Dentist (PCD) from the provider directory for yourself and each of your family members. Fill in the Provider ID number and Office ID number in the appropriate areas. If a selection is not made, a PCD will be assigned for you.

Primary Care Dentist No. _____ Primary Care Dentist Office No. _____

Dependent Information

New Enrollment/New Hire: Complete this section for all dependents you are choosing to enroll.
Add Dependent: Complete this section only for the dependents you are adding to your existing enrollment.
Terminate Dependent Coverage Only: Complete this section only for dependent(s) you are choosing to terminate.

Relation to Subscriber	Last Name	First Name & MI	Date of Birth**	Sex (M/F)	Primary Care Dentist Office ID #	Primary Care Dentist ID #
Spouse/ or Reg. Domestic Partner						
Child						
Child						
Child						
Child						
Child						

** Dependent child eligibility requirements are defined by the Employer Group Policy. Supporting documentation of dependent eligible status must be submitted with this form for dependent children age 19 or over for the enrollment to be processed and claims paid.

To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this application, including the information on the back of this application. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment application. I have read and agree to the notice on the back of this form.

MANDATORY BINDING ARBITRATION: Premier Access Insurance Company uses binding arbitration to settle disputes, including to settle claims of dental malpractice. The insured understands and agrees that if a dispute arises in connection with this policy, the parties waive the right to a jury trial and must settle the dispute through binding arbitration. The Premier Certificate of Insurance contains a provision that further addresses this issue Premier Access Insurance Company does not use binding arbitration in connection with any dispute that an insured's life insurance coverage.

Employee Signature: _____ **Date:** _____

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Other Dental Coverage

Do you or your dependents have other dental coverage? ❑ Yes ❑ No *(If yes, complete the information below.)*

Other Dental Coverage Information

Name of Insured: _____ Social Security Number: _____

Insured's Employer: _____ Name of Insurance Carrier: _____

Employer's Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Are your dependent children enrolled under your spouse's (or registered domestic partner) dental plan? ❑ Yes ❑ No

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE. THEREFORE, PREMIER ACCESS INSURANCE COMPANY WILL NOT REQUIRE THAT AN HIV TEST BE REQUIRED AS A CONDITION OF OBTAINING COVERAGE. IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFETY CODE SECTION 120980, PREMIER ACCESS INSURANCE COMPANY COMPLIES IN ALL RESPECTS WITH THE PROHIBITION AGAINST THE UNAUTHORIZED DISCLOSURES OF AN HIV TEST.

I, on my behalf and on behalf of my dependent(s) on this enrollment application, hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance, or agree that the contributions be added to my dues; (3) state that I became a full-time employee on the date stated on the reverse, and do currently work the number of hours per week stated on the reverse, (4) agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Premier* Certificate of Insurance, (5) agree that if I or my dependents receive dental services after my coverage is terminated or lapses, that I am responsible to reimburse Premier for any unrecovered payments made by Premier for such services, and (6) understand that verification of eligibility by Premier does not guarantee payment of claims and that retroactive eligibility changes supercede verifications of eligibility.

DENTAL RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby authorize Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. If you request, Premier will provide a copy to you of any information it discloses to third parties regarding your dental information. This Dental Release authorization shall remain in effect thirty months from the date the application is signed. This Dental Release authorization solely provides authorization of Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. The dental information is being collected by Premier solely for the specific purpose of premium underwriting..

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage , I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.