

# ENROLLMENT/CHANGE FORM

*United Concordia Life and Health Insurance Company  
a wholly owned subsidiary of*



**TYPE PROGRAM**

<input type="checkbox"/> Concordia Select
<input type="checkbox"/> ConcordiaFLEX

- New Enrollment
- Change (specify)
  - Add Dependent
  - New Address
  - Change of Employee Status
  - Cancel Coverage
  - Cancel Contract
  - Reinstate

EFFECTIVE DATE											
ENR SOURCE				GROUP NUMBER				SUB GROUP			

**NOTE: Incomplete information on this form will delay your enrollment. Please print clearly.**

Social Security Number		Employee Name (Last, First, Middle Initial)			Date of Birth	
Home Address					Home Phone (   )	
City		State		Zip Code	Work Phone (   )	
Date of Marriage /   /		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				
Previous Dental Insurance			Payroll Location			
Employer Name			Employer Address			
Date Hired /   /		Employee Number		Employee Type: <input type="checkbox"/> Current <input type="checkbox"/> New <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA		
Employee Status: <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried (Union Represented) <input type="checkbox"/> Management <input type="checkbox"/> Salaried (Not Union Represented) <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree						

**PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT.**

Last Name	First Name	MI	Sex	Date of Birth	Social Security
Self				/ /	- -
Dependent				/ /	- -
Dependent				/ /	- -
Dependent				/ /	- -
Dependent				/ /	- -

IF ANY OF THE CHILDREN LISTED ABOVE ARE HANDICAPPED (H), FULL-TIME STUDENT(S) AGE 19 AND OVER, PLEASE MARK AN "H", OR "S" BESIDE THE DEPENDENT'S NAME.

**Important:** Do you or your dependent(s) have other Group Dental Coverage?     Yes     No  
**If your answer to the above question is yes, please complete the following information.**

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number
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*Prior to signing I have read the reverse side.*

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Employer's Signature \_\_\_\_\_ Phone No: \_\_\_\_\_ Date: \_\_\_\_\_

I represent that all information supplied in this application is true and correct to the best of my knowledge and belief. All statements made shall be deemed representations and not warranties and shall not void or reduce the dental benefits unless in writing and signed by the appropriate parties. I agree to authorize any persons who shall make available to the Dental Director of United Concordia any photographs, records, study models or information regarding such services, if required, by United Concordia. Such information may also be released to persons or entities which at the direction of United Concordia are conducting administrative services review of the cost, quality and/or the appropriateness of service rendered to persons in United Concordia. This authorization is valid for the term of the Certificate not to exceed one year from the effective date. I understand that I am, or my authorized representative is, entitled to a copy of this authorization upon request.

Any person who includes any false or misleading information on this enrollment application is subject to criminal and civil penalties.