

**UnitedHealthcare Dental® Enrollment Form**

SOCIAL SECURITY NUMBER		EMPLOYEE ID NUMBER (if different than SSN)		<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel	<input type="checkbox"/> Change
				<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	
				<input type="checkbox"/> Date of Change: ____/____/____		
LAST NAME		FIRST NAME		MI	ENROLLEE'S DATE OF BIRTH	
ADDRESS			CITY	STATE	ZIP	
TELEPHONE NUMBER						<input type="checkbox"/> Male <input type="checkbox"/> Female
Home ( )						<input type="checkbox"/> Single <input type="checkbox"/> Married
Work ( )						
PLAN COVERAGE		<input type="checkbox"/> Single	<input type="checkbox"/> Employee + 1	<input type="checkbox"/> Family		
SELECT YOUR PLAN:		<input type="checkbox"/> Basic	<input type="checkbox"/> Premier	<input type="checkbox"/> Primary		

Please return completed application to: City of Memphis HR Department

**INFORMATION FOR DEPENDENT COVERAGE**

Spouse & Unmarried Dependent Children Only (Include Date of Birth)						
First Name	Initial	Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship**	Please provide Social Security number for each dependent	
				<input type="checkbox"/> Wife <input type="checkbox"/> Husband	<input type="checkbox"/> Dependent at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance: <input type="checkbox"/> Change <input type="checkbox"/> F _____ <input type="checkbox"/> Cancel CARRIER NAME
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Dependent at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance: <input type="checkbox"/> Change <input type="checkbox"/> F _____ <input type="checkbox"/> Cancel CARRIER NAME
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Dependent at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance: <input type="checkbox"/> Change <input type="checkbox"/> F _____ <input type="checkbox"/> Cancel CARRIER NAME
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Dependent at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance: <input type="checkbox"/> Change <input type="checkbox"/> F _____ <input type="checkbox"/> Cancel CARRIER NAME
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Dependent at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance: <input type="checkbox"/> Change <input type="checkbox"/> F _____ <input type="checkbox"/> Cancel CARRIER NAME

\*For court-ordered dependents, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.

**EMPLOYER INFORMATION – TO BE FILLED OUT BY EMPLOYER**

COMPANY NAME:		ENROLLEE EFFECTIVE DATE: (Mo/Day/Yr) ____/____/____		CLASS CODE:
ENROLLMENT: <input type="checkbox"/> New Hire <input type="checkbox"/> Other	DATE OF HIRE: (Mo/Day/Yr) ____/____/____	POLICY NUMBER:	PLAN VARIATION/REPORTING CODE:	PLAN CODE:
EMPLOYER AUTHORIZATION				

I confirm that the information I have provided on this form is complete and accurate.

I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other dental coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 60 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 60 days after such marriage, birth, adoption, or placement for adoption.

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.

The certificate provides dental benefits only. Review your certificate carefully.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*UnitedHealthcare Dental insurance products are either underwritten or provided by the following UnitedHealth Group companies: United HealthCare Insurance Company, Hartford, Connecticut (except in New York), United HealthCare Insurance Company of New York, Hauppauge, New York (New York only), Unimerica Insurance Company, Milwaukee, Wisconsin (except in New York), Unimerica Life Insurance Company of New York, New York, New York (New York only), or United Healthcare Services, Inc. UnitedHealthCare Dental Select HMO product is provided or administered by the following UnitedHealth Group companies: Dental Benefit Providers, Inc. (except in California), Dental Benefit Administrative Services (California only), Dental Benefit Providers of California, Inc., Dental Benefit Providers of Illinois, Inc., National Pacific Dental, Inc., Nevada Pacific Dental, Inc. or PacifiCare of Colorado, Inc.*

**PLEASE RETURN COMPLETED FORM TO THE HEALTH, WELLNESS & BENEFITS OFFICE.**

View the Dental Certificate of Coverage at: <http://www.memphistn.gov/framework.aspx?page+167>.