ConnectiCare Dental Plan Enrollment/Change Request Form

administered by Healthplex, Inc.

Refer to instructions on back before completing this form. Print clearly.

Subscriber Group Information - To Be Completed by Employer

Group Name	Subgroup	Plan & class info

A. Type of Activity - To Be Completed by Employer

1. Enrollment

☐ New Subscriber

Effective Date / /

Date of Hire / /

2. Change- *Check all that apply*

	Date of Event
☐ Add Spouse	/ /
☐ Add Dependent Child	/ /
☐ Name Change	/ /
☐ Change Plan	/ /
☐ Other	/ /

3. Remove or Terminate

Check all that apply

	Effective Date
☐ Remove Spouse	/ /
☐ Remove Dependent Child	/ /
☐ Subscriber Withdrawal/Termination	/ /

NOTE: Subscriber must be enrolled for spouse/dependent(s) to have coverage.

4. Continuation of Coverage, i.e., COBRA

Coverage For:

☐ Subscriber ☐ Dependents

Length of Continuation:

☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos

Date of Loss of Coverage: Date / /

of Qualifying Event: / /

B. Subscriber Information - Complete Sections B - G.

Social Security Number	Last Name, First Name, M. I.		Home Telephone ( )
Home Address	**Apt. No.**	**City, State**	**ZIP Code**
Employer Name			**Work Telephone** ( )
Work Address		**City, State**	**ZIP Code**

C. Plan Option

Please write in plan selection if more than one plan is being offered.

☐ _____

☐ _____

☐ _____

Your selection must be offered by your Employer

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M / F	Social Security Number	Birthdate MM / DD / YYYY
Subscriber					/ /
Spouse					/ /
Child					/ /
Child					/ /
Child					/ /

E. Other Dental Insurance

Is your spouse employed? ☐ **Yes** ☐ **No**

If "Yes," give name and address of spouse's employer.

If spouse or dependents have other dental coverage, give name, a policy number of insurance carrier, HMO, or other source.

F. Subscriber Signature

I represent that all of the information supplied in this application is true and complete.

If you have questions concerning the benefits and services provided by or excluded under the plan, contact a Member Services representative at ***855-973-2803*** *(TTY: 711), available 8 a.m. to 6 p.m., Monday through Friday, before signing this form.*

G. Employer Verification - To Be Completed by Employer

Subscriber Signature - ***Required***	Date	Employer Signature – ***Required***	Title	Date
	/ /			/ /

Subscriber copy may be used as a temporary ID card for 30 days from the effective date if authorized by the employer.

Instructions

Employer

- Complete the Employer Group Information in the upper right corner of the form.
- **Section A – Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section G - Employer Verification** in the lower right corner of the form.
- Sponsor must complete this section for all new enrollments, coverage changes, and terminations.
- Sponsor must sign and date the application for it to be processed.

Subscriber - Complete Sections [B - F].

Section B – Subscriber Information: Complete all information for your application to be processed.

Section C – Plan Option:

- Indicate plan name (where applicable).
- Select only an option offered by your Employer.

Section D – Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing, or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate sex, birthdate, and Social Security number for each individual listed.
- If you or your dependent(s) have other dental coverage, check the "Yes" box(es) and complete Section E – Other Dental Insurance.

Section E – Other Dental Insurance: Complete this section for all new enrollments or coverage changes.

Section F – Subscriber Signature:

- Complete this section for all new enrollments, coverage changes, and terminations.
- Subscriber must sign and date the application for it to be processed.

Section G – Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes, and terminations.
- Employer must sign and date the application for it to be processed.

Misrepresentation

Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

Conditions of Enrollment, Subscriber Acknowledgements, and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I authorize the sources stated below to give ConnectiCare, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment, or supplies for any physical or mental condition. Authorized sources are: any doctor or medical professional; any hospital, clinic, or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which ConnectiCare has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.
5. I acknowledge by enrolling in ConnectiCare dental plans, coverage is provided by ConnectiCare in accordance with the contract.
6. Enrollment of myself and of the listed dependents in the plan is effective on acceptance by ConnectiCare.
7. Coverage and benefits are contingent on timely payment of premiums and may be terminated as described in the plan documents. My employer is hereby authorized to withhold payments from my wages if appropriate.