Dental Enrollment Form

Group Dental Coverage Provided by
United HealthCare Insurance Company

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	☐ Enroll ☐ Cancel ☐ Change ☐ Waiver DATE : / /

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER HOME ( ) WORK ( )	☐ Male	☐ Female
	☐ Single	☐ Married

APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN DESIGN ☐ Standard Plan ☐ Low Option Plan Effective Date: / /

PLAN COVERAGE ☐ Employee ☐ Employee + One ☐ Family

PLAN COVERAGE ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

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			If Child is over 19, please indicate status and school	
		☐ Wife	☐ Husband	☐ M ☐ F	☐ Student at: _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel

*For court ordered dependent, 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.

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION

EFFECTIVE DATE

TYPE OF COVERAGE

Vision Enrollment - Add Optional MWG Vision Coverage ☐ Add Vision Coverage

PLAN COVERAGE ☐ Employee ☐ Employee + One ☐ Family

SIGNATURE _____

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement