

Enrollment Form

Group Dental Coverage and
Group Vision Care Insurance

Provided by United HealthCare Insurance Company of New York

UnitedHealthcare Dental®

SPECTRA
A UnitedHealth Group Company

Check the Appropriate Boxes

Requested Effective Date of Coverage / Date of Change: 01/01/2014						<input checked="" type="checkbox"/> Enroll	<input type="checkbox"/> Cancel	<input type="checkbox"/> Change
Reason:	<input checked="" type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Birth <input type="checkbox"/> Adoption/Legal Custody <input type="checkbox"/> Court ordered Dependent <input type="checkbox"/> Dependent married/reached age limit <input type="checkbox"/> Cobra/State Continuation <input type="checkbox"/> Other:							

Employee Information

Social Security Number: 149-46-3469		Date of Birth: 3/15/1968		
Last Name: SIMON		First Name: CAROLYN		Middle Initial:
Address: 71 TONJES ROAD				
City: CALICOON		State: NY		Zip Code: 12723
Home Phone: 845-796-9140		Work Phone: 212-683-9300		Email Address:
Sex: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

Product Selection

Plan Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse (or Domestic Partner*) <input checked="" type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family				
Person		Dental	Vision	If your Employer offers you a choice of dental plan, please indicate your Plan selection (e.g., Options PPO, Indemnity, INO SM), and Plan Code (e.g., P1211).
Employee		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Spouse (or Domestic Partner*)		<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Dependent		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Plan:		Plan Code:		

Family Information

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name	MI	Last Name (if different)	Date of Birth	Sex	Relationship**	Full-time Student
	Dependent Social Security Number						
<input type="checkbox"/> Enroll				/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner*	Not Applicable
<input type="checkbox"/> Change	SS# _____ - _____ - _____						
<input type="checkbox"/> Cancel							
<input checked="" type="checkbox"/> Enroll				2/29/2004	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No School Name:
<input type="checkbox"/> Change	SS# 669-22-4825						
<input type="checkbox"/> Cancel							
<input checked="" type="checkbox"/> Enroll				4/22/2006	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No School Name:
<input type="checkbox"/> Change	SS# 669-30-1405						
<input type="checkbox"/> Cancel							
<input type="checkbox"/> Enroll				/ /	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:
<input type="checkbox"/> Change	SS# _____ - _____ - _____						
<input type="checkbox"/> Cancel							
<input type="checkbox"/> Enroll				/ /	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:
<input type="checkbox"/> Change	SS# _____ - _____ - _____						
<input type="checkbox"/> Cancel							

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

Other Dental Coverage Information

On the day this coverage begins, will you, your spouse (or domestic partner*), or any of your dependents be covered under any other dental or vision plan or policy including another United HealthCare Insurance Company dental or vision plan or Medicare?

Yes No

Spouse (or Domestic Partner*)
Name:

Name of other Carrier:

Dependent Name:

Name of other Carrier:

Dependent Name:

Name of other Carrier:

Dependent Name:

Name of other Carrier:

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer.

Employee/Applicant Signature
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I understand that the dental and/or vision benefit plan I have selected provides reimbursement for certain dental and/or vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for dental and/or vision expenses which I have incurred may not be covered by my dental and/or vision benefit plan.

The Certificates provide dental and/or vision benefits only. Review your Certificates carefully.

FRAUD WARNING NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee/Applicant Signature:

Date:

12/30/2013

To Be Completed by Employer

Employer Name: VERATEX INC.

Enrollee Effective Date:
1/1/2014

Class Code:

Enrollment:
 New Hire
 Other

Date of Hire:
/ /

Policy Number:

Plan Variation/
Reporting Code:

Plan Code:

Employer Authorization:

Carrie Gross

[UnitedHealthcare Dental] and [Spectera] vision insurance products are underwritten or provided by: United HealthCare Insurance Company of New York, Hauppauge, NY.