

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 plan, policy or contract including another Dental Benefit Providers of California, Inc. dental 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:

Primary Dentist Information

Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered Dependents

Insured Name:	Dentist:	ID#:
Spouse (or Domestic Partner*) Name:	Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist:	ID#:
Dependent Name:	Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist:	ID#:
Dependent Name:	Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist:	ID#:
Dependent Name:	Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist:	ID#:

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

The Evidence of Coverage provides dental benefits only. Review your Evidence of Coverage carefully.

California Law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FRAUD WARNING STATEMENT: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits

Employee/Applicant Signature:	Date: / /
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To Be Completed by Employer

Employer Name:	Enrollee Effective Date: / /	Class Code:
Enrollment: <input type="checkbox"/> New Hire <input type="checkbox"/> Other	Date of Hire: / /	Contract Number:
	Plan Variation/Reporting Code:	Plan Code:

Employer Authorization:

UnitedHealthcare Dental insurance products are underwritten or provided by: Dental Benefit Providers of California, Inc.