CA Dental HMO Individual Plan Change of Status Form (COS)

UnitedHealthcare Dental®

Select your Group ID: ☐ SGV160 ☐ SG590 ☐ SGV161 ☐ SGV100 ☐ SGFEDCA

Please note: If tier change results in rate change, be sure to send the payment for the rate difference along with your request.

IMPORTANT: See other side for instructions. Please print neatly and complete all sections.

1. Purpose of Form

For Change
Check all that apply:

☐ Name Change
☐ Provider (Dentist) Change
☐ Address Change
☐ Telephone Change
☐ Dependent add _____ / _____ / _____
☐ Dependent term _____ / _____ / _____
☐ Terminate all coverage _____ / _____ / _____
☐ Subscriber deceased _____ / _____ / _____

For Dependent Change

Request must be received by the 20th of the month to be effective the 1st of the following month. Attach documentation or date of the change. ☐☐/☐☐/☐☐

Check one:

☐ Marriage ☐ Newborn ☐ Divorce ☐ Legal Guardianship ☐ Adoption/Placement
☐ Handicap ☐ Domestic Partnership ☐ Other

2. Subscriber (You)

Last Name

First Name | MI

Date of Birth | Sex ☐ M ☐ F | Social Security Number | or Subscriber ID

Mailing Address

Apt # (or secondary address information)

City | City | Zip

Home Phone # | Work Phone #

Cell Phone # | Email

Signature Value | Provider Number | Dentist's Name/City | Existing Patient? ☐ Yes ☐ No

3. Change In Coverage

Important: Identify the individuals to be covered after changes.

From:
Former Individual(s) to be covered:
☐ Self
☐ Self + Spouse
☐ Self + Child(ren)
☐ Self + Family

To:
New Individual(s) to be covered:
☐ Self
☐ Self + Spouse
☐ Self + Child(ren)
☐ Self + Family

For a list of Change to UnitedHealthcare DentalSignatureValue Dental Providers in your area, visit **myuhc.com**. Choose CA-DHMO Legacy Pacificare.

4. Dependents

■ For Additional Dependents, check here and attach additional sheet.

1

Last Name | First Name | MI

☐ Add ☐ Remove
Relationship:
☐ Spouse
☐ Domestic Partner
☐ Daughter
☐ Son
Signature Value

Date of Birth | Sex ☐ M ☐ F | Social Security Number

Provider Number | Dentist's Name / City | Existing Patient? ☐ Yes ☐ No

2

Last Name | First Name | MI

☐ Add ☐ Remove
Relationship:
☐ Spouse
☐ Domestic Partner
☐ Daughter
☐ Son
Signature Value

Date of Birth | Sex ☐ M ☐ F | Social Security Number

Provider Number | Dentist's Name / City | Existing Patient? ☐ Yes ☐ No

3

Last Name | First Name | MI

☐ Add ☐ Remove
Relationship:
☐ Spouse
☐ Domestic Partner
☐ Daughter
☐ Son
Signature Value

Date of Birth | Sex ☐ M ☐ F | Social Security Number

Provider Number | Dentist's Name / City | Existing Patient? ☐ Yes ☐ No

I understand and agree to the terms and conditions on the reverse side of this sheet.

Enrollee Signature X_____ Date _____

Instructions for completing this Form

1) **Check all appropriate boxes and print all information clearly:** It is important that you check all appropriate boxes listing all of your changes and mark the reason you are changing information.
2) **Subscriber:** This section must always be filled out completely. If you are on a UnitedHealthcare Dental SignatureValue dental plan, remember to indicate the **Dental SignatureValue Dental Provider number/dentist/city** you have selected.
   For a list of Provider (Dentists) in your area, visit myuhc.com. Choose CA-DHMO Legacy Pacificare Network.
3) **Selected Coverage:** Please indicate the individuals to be covered after the changes.
4) **Dependents:** All dependents you wish to add or remove should be listed in this section. If your dependents are on a UnitedHealthcare Dental SignatureValue dental plan, remember to indicate their **Dental SignatureValue Dental Provider number/dentist/city** selections.
5) **Return completed form** by **fax** — 714-784-3730, **email** — IndividualDHMODental@uhc.com, or **mail** to address as noted below.

This form cannot be processed if information is incomplete.

TERMS AND CONDITIONS Please complete all sections. This form cannot be processed if information is incomplete.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare Dental or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than $5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than $5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in UnitedHealthcare Dental both member (including any heirs or assigns) and UnitedHealthcare Dental entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage. Request for dis-enrollment or changes in coverage must be received in writing by the 20th of the month to be effective same month. You can fax, mail or email changes:

Fax: 714-784-3730

Email: IndividualDHMODental@uhc.com

Mail: ATTN: M/S CA124-0152
UnitedHealthcare Dental
PO Box 6020
Cypress, CA 90630-0020