Individual dental plan enrollment form.

Instructions for completing enrollment form.

- Check all appropriate boxes and print all information clearly. This form cannot be processed if information is incomplete.
- Statement of Understanding: Read and sign the Statement of Understanding on the back page. **Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the first of the following month.**
- When completed, you can send this form using fax, email or mail.

Fax: 714-784-3730
Email: IndividualDHMODental@uhc.com
Mail: ATTN: M/S CA 124-0152
UnitedHealthcare Dental
P.O. Box 6020
Cypress, CA 90630-0020

Subscriber (you)

Complete all sections. Include your primary care dentist information.

Last Name		First Name		Middle Initial
Sex ☐M ☐F	Date of Birth / /	SSN / /	Home ( )	
Address	City	State	ZIP Code	Work ( )
Dentist Provider Number	Dentist Name/City		Have you received treatment from this dental office? ☐Yes ☐No	
Email Address		Cell ( )		

Dependents (your spouse and/or children)

Complete all sections. Include the primary care dentist information for each dependent. Each dependent can have their own dentist.

#				
1	Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial
	Sex ☐M ☐F	Date of Birth / /	SSN / /	
	Dentist Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No	
2	Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial
	Sex ☐M ☐F	Date of Birth / /	SSN / /	
	Dentist Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No	
3	Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial
	Sex ☐M ☐F	Date of Birth / /	SSN / /	
	Dentist Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No	
4	Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial
	Sex ☐M ☐F	Date of Birth / /	SSN / /	
	Dentist Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No	

If you have more dependents: Please provide all details on another sheet of paper and submit with this form.

Payor (if not you)

This section must be completed by the individual who will be responsible for paying for the plan.

Last Name	First Name	Middle Initial	Email Address
Address	City	State	ZIP Code

REQUESTED EFFECTIVE DATE: ____/____/________ (MM/DD/YYYY)

See back page to:
- Read and sign the Statement of Understanding section.
- Complete payment information.

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge or belief. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by UnitedHealthcare with this application; (b) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (c) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that, for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by UnitedHealthcare. I understand that, for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the postmark date affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S.Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by UnitedHealthcare. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X ______________________ X ______________________ X ______________________

Proposed Insured's Signature | State where you signed this application | Date you signed and read application

X ______________________ X ______________________ ☐☐☐☐☐☐☐☐☐☐

Broker Printed Name | Broker Email | Broker Number

IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. Altered applications will not be accepted.

Payment Options

Check the appropriate boxes for the payment options you will be using. **Important: You will be asked to pay a one-time non-refundable enrollment and processing fee of $15.00 in addition to your initial payment.**

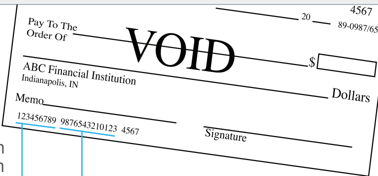
1 Choose Payment Frequency:

☐ **Monthly** (Pay your monthly premium automatically from your checking account, manually by check or by credit card.)

☐ **Annually** (Pay your full annual payment upfront by check or credit card and you will save 3.5 percent on your total premiums.)

2 Choose Method of Payment:

☐ **Automatic Payment(s)**



I (we) hereby authorize UnitedHealthcare to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account. I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Type of Account: ☐ Checking ☐ Savings

Nine-digit Routing Number ☐☐☐☐☐☐☐☐☐

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution's Name ______________________

Address ______________________

City, State, ZIP ______________________

The auto debit process is 7 calendar days prior to the last day of the month except when that day is Saturday; then it will be Sunday. Please have your funds available for withdrawal on this day.

X ______________________

Authorized Account Signature

☐ **Payment(s) by Mail** (Mail to: ATTN: M/S CA 124-0152; UnitedHealthcare Dental; P.O. Box 6020; Cypress, CA 90630-0020)

☐ **Credit Card** (Call **1-800-228-3384** and ask for "Billing.")

Calculate first payment

Enter Plan Number: (Located on your brochure or benefit summary.)	
Enter your FIRST MONTH premium payment:	$
Add the one-time non-refundable enrollment and processing fee:	$15.00
Enter first payment total:	**$**

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