Dentsured

Dentsured Inc.

A. Type of Activity – to be completed by [Applicant] *Refer to instructions [on back] before completing this form. Print clearly.*

	Activity – Check all that apply	Date of Event	Reason
ADD	☐ Enrollment of a new [Insured/Enrollee/Subscriber] ☐ Add Spouse[/Civil Union Partner] [☐ Add Civil Union Partner] ☐ Add Domestic Partner ☐ Add Dependent Child	_____/_____/_____ _____/_____/_____ [_____/_____/_____] _____/_____/_____ _____/_____/_____	_____ _____ [_____] _____ _____
REMOVE	[☐ Remove [Insured/Enrollee/Subscriber]] ☐ Remove Spouse[/Civil Union Partner] [☐ Remove Civil Union Partner] ☐ Remove Domestic Partner ☐ Remove Dependent Child	_____/_____/_____ _____/_____/_____ [_____/_____/____] _____/_____/_____ _____/_____/_____	_____ _____ [_____] _____ _____
OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Special Enrollment Period (due to a Triggering Event*) ☐ Other ☐ Add/Change Office ID Numbers: Primary Dentist **See list of Triggering Events in Instructions[; provide evidence of the triggering event with the enrollment form.]*	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____ _____

B. [Applicant] Information

Name (Last, First, MI):

SSN:

Birthdate (mm/dd/yyyy)

☐ Male
☐ Female

[Email:
By providing an email address you consent to receive information, including the policy, by electronic means.]

Are you a resident of New Jersey? ☐ Yes ☐ No

Do you maintain a home in any other state or country? ☐ Yes ☐ No *If yes:*
Name of State/Country:_____ Number of months you live there each year: _____

Address Information

Primary Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Other Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:
[Mailing address (for communications other than bills): ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:]

Activity

☐ Add ☐ Remove ☐ Other Change ☐ Continue *If a name change, indicate prior name:*

[Primary Loc #:]_____
address: zip+4] [NPI #:]

[Current Patient: ☐ Yes ☐ No]

	[Ob/Gyn Loc #:]_____ address:] zip+4	[NPI #:]	[Current Patient: ☐ Yes ☐ No]
	[Dentist Loc #:]_____ address:] zip+4	[NPI #:]	[Current Patient: ☐ Yes ☐ No]

Are you eligible for Medicare? ☐ Yes ☐ No
Are you covered under Medicare Parts A or B? ☐ Yes ☐ No
Please note: If you are eligible for Medicare, the individual policy will coordinate as secondary payor to what Medicare paid or would have paid. Individual policies do not operate as Medicare supplement policies.

Are you covered under any health coverage? ☐ Yes ☐ No
If yes, why are you applying for individual coverage?
_____

C. Plan Option – *Check or circle desired plan*

Plan A Dental Hygiene Plus and $0 Copay and or $0 Deductible-Premium:$139.00 per month

Plan B Comprehensive Dental and $0 Copay and or $0 Deductible-Premium:$199.00 per month

Plan C Denture/Prosthesis and $0 Copay and or $0 Deductible-Premium:$139.00 per month

Plan C+ Monthly Denture Cleaning and $0 Copay and or $0 Deductible Premium:$29.00 per month

D. Other Individuals Covered – *Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. [Attach proof of disability.]*

1. Spouse/Domestic Partner/Civil Union Partner	**2. Child**	**3. Child**	**4. Child**
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No

[Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No]]	[Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No]]	[Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No]]	[Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No]]
[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]
[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No ☐ NA]]	[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]
If last name is different from [Applicant's], please explain: _____	If last name is different from [Applicant's], please explain: _____ _____	If last name is different from [Applicant's], please explain: _____ _____	If last name is different from [Applicant's], please explain: _____ _____
Home address same as [Applicant]? ☐ Yes ☐ No *If NO, complete Section [E]*	Home address same as [Applicant]? ☐ Yes ☐ No *If NO, complete Section [F]*	Home address same as [Applicant]? ☐ Yes ☐ No *If NO, complete Section [F]*	Home address same as [Applicant]? ☐ Yes ☐ No *If NO, complete Section [F]*

NONGROUP ENROLLMENT/CHANGE REQUEST

[E.] Additional Spouse/Domestic Partner/Civil Union Partner Information – *If not applicable, please mark as "NA."*

a. Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:	b. Please explain why the address is different: _____ _____

[F.] Additional Child Information – *Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____	Name(s):_____
Street/Apt:_____	Street/Apt:_____
Street/Apt:_____	Street/Apt:_____
City, State, Zip Code: _____	City, State, Zip Code:_____
Reason:_____	Reason:_____

[G.] Race/Ethnicity – *Response is appreciated but NOT required!*	*Choose a category that most closely describes you:* ☐American Indian or Alaskan Native ☐Black, not of Hispanic origin ☐Hispanic ☐Asian or Pacific Islander ☐White, not of Hispanic origin
[H.] Payment Information – *indicate how you would like to [be billed and] make payment*	[☐ Monthly ☐ Check [☐Credit Card Type (AMEX, Visa, etc.):_____ [☐ Quarterly] ☐ Money Order No.:_____ Exp. Date: ____/____/____ [☐ Semi-annually]] [☐Automatic Bank Draft (*attach voided check*)] Cardholder Name: [☐Debit Card Type (AMEX, Visa, etc.):_____ No.:_____ Exp. Date: ____/____/____ Cardholder Name:] [Information to visit website to authorize payment via credit and/or debit card.]

[I.] [Applicant's] Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form Signature:		Date:
[J.] Broker/General Agent Signature	Signature of Preparer	Date / /	NJ Producer License #
	General Agent		Agent ID #

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- ☆ Except for section [G], you must complete sections A through [I], and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- ☆ Please PRINT except when a signature is requested.
- ☆ If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- ☆ If you are applying to add a spouse, civil union partner, domestic partner, or child please check the applicable box in the "Add" section in A **and** identify the applicable triggering event in the reason section "Other Change" section in A.
- ☆ Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled for Medicare. Covered under Medicare Parts A or B mean you have Medicare and CANNOT enroll for an individual plan.
- ☆ You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's [NPI] number [from the provider directory] [or] [and] at: www.dentsured.com [or] [and] [by contacting the provider directly.] Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one [NPI]number. You should confirm the correct [NPI] number for the specific provider and office location where you will be seen by contacting that office directly.
- ☆ For provider addresses, include the zip code plus the four digit extension (9 digits)
- ☆ IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this [policy], contact a [member services] representative at [phone number] before signing this form.
- ☆ [KEEP] [MAKE] A COPY OF THIS COMPLETED APPLICATION! [A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by [Dentsured Inc]. Coverage must be verified with [Dentsured Inc] prior to visiting with a specialist or admission to a hospital.]
- ☆ Triggering Events:
  1. loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium
  2. dependent attained age 26 or 31 and lost coverage
  3. Marketplace changed your subsidy determination
  4. New dependent due to marriage, birth, adoption or placement for adoption, placement in foster care
  5. .gained access to New Jersey plans as a result of permanent move to New Jersey
  6. child support order or other court order requiring coverage

[Please note: You must provide evidence of the triggering event with your enrollment form.]

Eligibility [for health benefit plans]

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).
B. You MUST be a New Jersey resident which means your primary residence is in New Jersey
C. You must not be enrolled for Medicare Parts A or B.
D. If application is made for the Catastrophic Plan the following additional requirements apply:
   1. You must be under 30 years old; OR
   2. You must have a Certificate of Exemption from the Marketplace. Attach a copy to your application.

The **Annual Open Enrollment Period** is the designated period of time each year during which you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. Your application must be received during the designated Annual Open Enrollment Period. The effective date of coverage applied for by December 31will be January 1 of the immediately following year. *If* the designated Annual Open Enrollment Period extends beyond December, the effective date of coverage will be the first [or fifteenth] of the month following the date of the application.

A **Special Enrollment Period** that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the first [or fifteenth] of the month following receipt of the application. In addition if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event.

NOTE: If you currently have coverage the plan for which you are applying must REPLACE the current coverage but you SHOULD NOT terminate it until the new coverage is effective.

[Eligibility for ancillary products]

CONDITIONS OF ENROLLMENT -- [APPLICANT] ACKNOWLEDGEMENTS AND AGREEMENTS
On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that: 1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Dentsured Inc, or any consumer reporting agency acting on behalf of [Dentsured Inc], information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date. 2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that [Dentsured Inc] has taken in reliance on the authorization. 3. I understand I may receive a copy of this authorization if I request one. 4. I agree [Carrier] will provide coverage in accordance with the terms of the contract for the individual [plan] [policy]. 5. I understand that my enrollment and the enrollment of my listed dependents in [Carrier's Name's] individual [plan] [policy] is subject to acceptance by [Carrier's Name]. 6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual [plan] [policy] if premiums are not paid timely.
MISREPRESENTATIONS
Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form [for a health benefits plan] is subject to criminal and civil penalties.

Carrier instructions

(not to be included in the Nongroup Enrollment/Change Request form when printed by the carrier)

1. Carrier should insert its logo and name where indicated, or leave the table blank, or blacked-out.
2. Carrier must replace bracketed text "Carriers Name" with carrier's full name throughout the document.
3. Replace "on back" with appropriate directions if the instructions are not provided on the reverse side.
4. If the carrier refers to the "Enrollee/Subscriber" using another term such as "Member" or "Applicant" or some similar term, replace the term "Enrollee/Subscriber" with such other term throughout the document.
5. In Section A, carrier may choose to put Civil Union Partner on the same line as Spouse, or on a separate line.
6. In Section A, omit "Add/Change Office ID Numbers" options if carrier does not offer such options.
7. In Section B, references to the e-mail address should be omitted if the contact option is not offered.
8. At Section B and D, references to primary, ob/gyn and Dentist selections, with LOC and NPI numbers should not be included if selections are not an option or a requirement. If a carrier does not assign numbers for each office location, then carriers may indicate that LOC refers to the office location in the selection information, and request that enrollees identify a name for the office location. However, carriers should not request complete office address locations. Allow selection of PCP for plans for which PCP selection is allowed or required.
9. At Section B and D, omit reference to current patient status, if the carrier does not require the information.
10. At Section C, insert carrier plan options and deductibles, coinsurance or copayment options. Listed medical plan options must be consistent with the requirements of N.J.A.C. 11:20-3. If pediatric dental coverage is not embedded include text to obtain a reasonable assurance that the applicant has separately bought pediatric dental coverage. Any available additional benefits such as adult dental and adult vision benefits may be listed.
11. At Section D, if the carrier does not require proof of disability, omit the directions to attach proof.
12. If Section [E] is omitted, renumber Sections F through L accordingly.
13. At Section I, omit those payment options or modes that are unavailable (but note: carriers must permit payment on a monthly basis).
14. At Section [K], omit reference to agents if the carrier does not use them in the sale of individual policies. The text may be modified to include the specific broker/general agent information the carrier requires. The scope of the information included is limited to information concerning the broker/general agent or agent.
15. In the Instructions, if carrier uses a term other than "Member Services," the carrier should insert that term, and must include the appropriate contact phone number.
16. In the Instructions, carrier must insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
17. In the Instructions, if you require selection of health care providers, insert appropriate information on how to obtain correct NPI numbers. Note that indicating information is available only through a website is not appropriate.

18. At the Footnote, if a carrier does not utilize an "Internal Carrier Form Number," the carrier may omit the reference.
19. Carriers should add information regarding eligibility for ancillary products, if any.