United Concordia Insurance Company
a wholly owned subsidiary of
UNITED CONCORDIA
America's Premier Dental Insurer

ENROLLMENT/CHANGE FORM

TYPE PROGRAM

- ☐ ConcordiaPLUS
- ☐ Concordia Select
- ☐ Concordia Preferred
- ☐ ConcordiaFLEX

- ☐ New Enrollment
- ☐ Change (specify)
  - ☐ Add Dependent
  - ☐ New Address
  - ☐ Change of Employee Status
  - ☐ Cancel Coverage
  - ☐ Cancel Contract
  - ☐ Reinstate

EFFECTIVE DATE
/ /

ENR SOURCE

GROUP NUMBER	SUB GROUP

NOTE: Incomplete information on this form will delay your enrollment. Please print clearly.

Social Security Number	Employee Name (Last, First, Middle Initial)		Date of Birth
Home Address			Home Phone ( )
City	State	Zip Code	Work Phone ( )
Date of Marriage / /	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		
Previous Dental Insurance		Payroll Location	
Employer Name		Employer Address	
Date Hired / /	Employee Number	Employee Type: ☐ Current ☐ New ☐ Rehire ☐ Open Enrollment ☐ COBRA	
Employee Status: ☐ Hourly ☐ Salaried (Union Represented) ☐ Management ☐ Salaried (Not Union Represented) ☐ COBRA ☐ Retiree			

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT.

Last Name	First Name	MI	Sex	Date of Birth	Social Security	ConcordiaPLUS, Primary Care Dentist No. (See listing)
Self				/ /	- -	
Dependent				/ /	- -	
Dependent				/ /	- -	
Dependent				/ /	- -	
Dependent				/ /	- -	

IF ANY OF THE CHILDREN LISTED ABOVE ARE HANDICAPPED (H), FULL-TIME STUDENT(S) AGE 19 AND OVER, PLEASE MARK AN "H", OR "S" BESIDE THE DEPENDENT'S NAME.

Important: Do you or your dependent(s) have other Group Dental Coverage? ☐ Yes ☐ No

If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number

Prior to signing I have read the reverse side.

Employee's Signature _____ Date: _____

Employer's Signature _____ Phone No: _____ Date: _____

Personal information may be collected from persons other than an individual proposed for coverage. This information may be collected from persons other than an individual proposed for coverage. The information, as well as other personal or privileged information subsequently collected by UNITED CONCORDIA INSURANCE COMPANY, or its agent, in certain circumstances, may be disclosed to third parties without authorization. Subscribers have the right to access and correct all personal information collected. The notice prescribed in the Virginia Insurance Laws will be furnished to the Subscriber upon request. UNITED CONCORDIA INSURANCE COMPANY shall not disclose any personal or privileged information or genetic information about an insurance transaction unless the disclosure is accomplished in accordance with the Virginia Insurance Laws. Collecting this information is for the purpose of: determining eligibility for enrollment; benefit payments and administrative review.

I agree to authorize any persons who shall have rendered services to me or my dependents, if any, under the Certificate to make available to the Dental Director of UNITED CONCORDIA INSURANCE COMPANY any photographs, records, molds, or information regarding such services, if required, by UNITED CONCORDIA INSURANCE COMPANY. Such information may also be released to persons or entities which at the direction of UNITED CONCORDIA INSURANCE COMPANY are conducting administrative services review of the cost, quality and/or the appropriateness of service rendered to persons in UNITED CONCORDIA INSURANCE COMPANY. This authorization is valid for thirty months from the date this authorization is signed. I understand that I am, or my authorized representative is, entitled to a copy of this authorization upon request.