

# NORTHWESTERN UNIVERSITY

## Dental Insurance Enrollment and Policy Change Form

*Please print - Leave shaded areas blank*

## Participants on LOA

### APPLICATION INFORMATION

Check here if this is an Open Enrollment application

<b>MEMBERSHIP:</b> <input type="checkbox"/> COBRA  <input type="checkbox"/> Retiree	<b>CHANGES:</b> <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Change Dental Group <input type="checkbox"/> Dropping Dependents <input type="checkbox"/> Adding Dependents ( <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption)	<b>GROUP #</b> For Office Use Only  <b>SECTION #</b>
<b>DATE OF QUALIFYING EVENT:</b>	<b>OTHER CHANGE:</b>	<b>EFFECTIVE DATE:</b>

### PERSONAL INFORMATION

<b>NAME</b> Last                                      First                                      M.I.		<b>SOCIAL SECURITY NO.</b>	<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>ADDRESS</b> Street                                      Apt.                                      City                                      State                                      Zip			
<b>DATE OF BIRTH:</b>	<b>DATE OF HIRE:</b>	<b>HOME PHONE:</b>	<b>WORK PHONE:</b>
<b>MARITAL STATUS:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			

### DENTAL PLAN AND GROUP SELECTION

Please select the dental plan and type of coverage you wish to enroll in:

<input type="checkbox"/> Dental Maintenance Organization (First Commonwealth DMO Plan 3000A) <input type="checkbox"/> Indemnity Dental Plan (Blue Cross/Blue Shield PreDent)	<input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage	<b>DMO Dental Location Code</b>  <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%;"></td> <td style="width: 33%;"></td> </tr> </table>			
<b>NOTE:</b> If you are selecting First Commonwealth DMO, please refer to the plan brochure and indicate a 3-digit dentist location code in the space to the right. Each covered family member may select a separate dentist location. If you do not select a dentist location code, one will be assigned for you.					

### DEPENDENT INFORMATION

List any dependents to be covered by the plan

Relationship	Date of Birth			Last Name (If Different)	First Name	Social Security Number	DMO ONLY Dental Location Code	Internal Use Only
	Mo	Day	Yr					
Spouse								
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								

### OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Dental Insurance?    Yes    No   If yes, complete the following:

<b>NAME OF INSURED:</b>	<b>EMPLOYER:</b>	<b>POLICY NUMBER:</b>
<b>INSURANCE COMPANY NAME:</b>	<b>INSURANCE COMPANY ADDRESS:</b>	

### AUTHORIZATION

(1) I elect coverage under the above-selected dental care plan on behalf of myself and the above-listed dependents, and I authorize any payroll deductions required. (2) I certify that the above information is correct to the best of my knowledge and belief. (3) I hereby authorize any licensed dentist, hospital, clinic, government agency or other dental or medically-related facility, insurance company, organization or institution that has any records or knowledge of my dental or the dental of any member of my family to exchange such information with the above-selected dental care provider—including, without limitations, information relating to mental illness or use of drugs or alcohol. I understand that the information will be used for the purpose of review, investigation, or evaluation of coverage claims for dental insurance benefits provided to me and/or any of my dependents. (4) I agree to abide by the terms and conditions of the Plan Document and Certificates of Insurance.

This authorization is valid for the term of coverage of the contract under which this dental care enrollment is effective. I am aware of my right to receive a copy of the authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

SIGNATURE

DATE