



NORTHWESTERN
UNIVERSITY

Dental Plan Enrollment Form
(The Benefits Division will accept original forms only)

COBRA Participants

ACTION		MEMBERSHIP INFORMATION	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Former Employee	
<input type="checkbox"/> Dropping Dependents	<input type="checkbox"/> Address Change	<input type="checkbox"/> Dependent/Spouse	
<input type="checkbox"/> Terminate Coverage	<input type="checkbox"/> Other		

PERSONAL INFORMATION

NAME		EMPLOYEE ID		GENDER	
Last	First	M.I.	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
HOME ADDRESS		City		State	Zip
Street	Apt.				
DATE OF BIRTH:	CHANGE EFFECTIVE DATE:	E-MAIL:	HOME PHONE:		
___/___/___	___/___/___		(____) _____ - _____		
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					

DENTAL SELECTION

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

I ELECT TO:		<input type="checkbox"/> First Commonwealth DHMO Plan		<input type="checkbox"/> You <input type="checkbox"/> You + child(ren)	
<input type="checkbox"/> continue <input type="checkbox"/> drop <input type="checkbox"/> change		<input type="checkbox"/> BlueCross BlueShield PPO Plan		<input type="checkbox"/> You + spouse <input type="checkbox"/> You + spouse + child(ren)	
DENTAL INSURANCE COVERAGE		Plan cannot be changed at initial enrollment			
Office Use Only		Coverage Effective Date		Group and Section Number	
<input type="checkbox"/> Submitted to Provider					
<input type="checkbox"/> Entered into HRIS					

OTHER INSURANCE INFORMATION

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

NAME OF INSURED:	EMPLOYER:	POLICY NUMBER:
INSURANCE COMPANY NAME:	INSURANCE COMPANY ADDRESS:	

DEPENDENT INFORMATION

Please select whether you want your dependent to be covered under your Dental plan

Relationship	Date of Birth	Name (Last [if different], First MI)	Continue/Drop
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom Partner	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop

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

PLEASE RETAIN A COPY FOR YOUR RECORDS