



NORTHWESTERN UNIVERSITY

Dental Plan Enrollment Form

(The Benefits Division will accept original forms only)

Retiree Participants

ACTION

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Open Enrollment
<input type="checkbox"/> Name Change	<input type="checkbox"/> Address Change
<input type="checkbox"/> Dropping Dependents	<input type="checkbox"/> Other

PERSONAL INFORMATION

NAME Last First		M.I.	SOCIAL SECURITY # ____ - ____ - _____		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
HOME ADDRESS Street		Apt.	City		State	Zip
DATE OF BIRTH: __/__/____		DATE OF RETIREMENT: __/__/____		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"/> continue <input type="checkbox"/> drop <input type="checkbox"/> change DENTAL INSURANCE COVERAGE		<input type="checkbox"/> You <input type="checkbox"/> You + spouse	<input type="checkbox"/> You + child(ren) <input type="checkbox"/> You + spouse + child(ren)
<input type="checkbox"/> First Commonwealth DHMO Plan	<input type="checkbox"/> Blue Cross & Blue Shield PPO Plan	DHMO Dental Location Code:	Coverage Effective Date
		Group and Section Number	

OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Health or 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 Health and/or Dental plan

Relationship	Date of Birth	Name (Last [if different], First MI)	Social Security #	HMO Primary Care Physician	Add/Drop
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom Partner	__/__/__		____ - ____ - _____		<input type="checkbox"/> Add <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	__/__/__		____ - ____ - _____		<input type="checkbox"/> Add <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	__/__/__		____ - ____ - _____		<input type="checkbox"/> Add <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	__/__/__		____ - ____ - _____		<input type="checkbox"/> Add <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