



NORTHWESTERN UNIVERSITY
2002 Dental Plan Enrollment Form
Visiting Scholars



MEMBERSHIP INFORMATION

STATUS: <input type="checkbox"/> Visiting Scholar	ACTION: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Dropping Dependents	<input type="checkbox"/> Adding Dependents <input type="checkbox"/> Birth, Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage, VISA entry (please attach documentation)
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PERSONAL INFORMATION

NAME	Last	First	M.I.	SOCIAL SECURITY #	SEX
				____ - ____ - _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
HOME ADDRESS	Street	Apt.	City	State	Zip
E-MAIL:			HOME PHONE:	CAMPUS PHONE:	
			(____) _____ - _____	__ - _____	
DATE OF BIRTH	DATE OF HIRE	MARITAL STATUS	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	
___/___/_____	___/___/_____	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	

DENTAL SELECTION

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

SELECT TO: <input type="checkbox"/> enroll in <input type="checkbox"/> drop <input type="checkbox"/> change plan DENTAL INSURANCE COVERAGE	If you are enrolling in the dental plan for the first time, and you have chosen Blue Cross/Blue Shield Pre-dent, you will have to complete a BC/BS Statement of Good Dental Condition form for each family member you wish to cover. These statement forms, as well as this enrollment form must be received by the due date, or your coverage will not go into effect. If you are adding members to your BC/BS dental, you will have to complete the BC/BS Statement of Good Dental Condition for each member you are adding.		
<input type="checkbox"/> First Commonwealth DMO Plan 3000A → → <input type="checkbox"/> Blue Cross & Blue Shield PreDent - Indemnity Plan	<input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage	DMO Dental Location Code:	
Office Use Only: <input type="checkbox"/> Entered into HRIS <input type="checkbox"/> Submitted to Provider	Coverage Effective Date	Group and Section Number	

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:	
Are you covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is your spouse? <input type="checkbox"/> YES <input type="checkbox"/> NO	If over 65: <input type="checkbox"/> Presently employed <input type="checkbox"/> Retired

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)	Social Security #	Add/Drop
Spouse	___/___/___		____ - ____ - _____	<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