GOLDEN WEST DENTAL & VISION

Golden West Dental & Vision offers dental and vision HMO plans for California employees.
UniCare Life & Health Insurance Company offers dental PPO plans nationwide.

EMPLOYEE ENROLLMENT FORM

INSTRUCTIONS:

1. **You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full; all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. If you are declining all coverage, please complete Sections 1 and 4 only.
4. **Print clearly using blue or black ink.**

① EMPLOYEE INFORMATION – *Must be completed by employee.*

❑ New Group enrollment ❑ New hire ❑ Re-enrollment	❑ Change coverage selection ❑ Other (please explain)_____	❑ COBRA ❑ Cal-COBRA* **Cal-COBRA applicants must submit first month's premium*	Requested Effective Date: MM//DD//YY ____/____/____

Social Security No.	Last Name	First Name	Initial	Marital Status
– –				❑ Single ❑ Married

Street Address	Apt #	City	State	Zip Code

Home Phone No.	Full-Time Date of Hire MM/DD/YY	No of Hours Worked Per Week	Occupation/Job Title
( )	/ /		

Name of Employer	Group #	Div #	Business Phone No.
			( )

② DENTAL COVERAGE SELECTION – *Please verify with your employer which plans are available. Check only one Dental Plan.*

HMO Dental Plans*				PPO Dental Plans		
If you choose an HMO dental plan, you must select a Network General Dentist, Orthodontist, and Vision Provider for each family member (up to 3 General Dentists, Orthodontists, and Vision Providers per family). If you do not select a provider, one will be selected for you within 30 days of enrollment. ***HMO dental plans are available to California Residents only.**				If you choose a PPO dental plan, you do not need to select a dentist. You can access benefits from any provider; however, you will pay less out of pocket if you choose a PPO network dentist. If your PPO plan option includes an HMO vision or orthodontic plan, you may select an HMO vision or orthodontic provider. Please verify plan options with your benefits manager.		
❑ 89L1 ❑ 89L2 ❑ 89L3 ❑ 89L123 ❑ 89L23	❑ 89L1C ❑ 89L2C ❑ 89L3C ❑ 89L123C ❑ 89L23C	❑ Preferred Choice ❑ PA 100 ❑ SmileChoice 100 ❑ SmileChoice 200	❑ SA2 ❑ DP2 ❑ _____	❑ PPO Plan (Non-Voluntary)	❑ Voluntary PPO	High/Low PPO: ❑ High Option ❑ Low Option
				For Office Use Only CPT: _____ months Date: ____/____/____		

③ EMPLOYEE/DEPENDENT INFORMATION – *List yourself and only those eligible dependents who are enrolling.*

An eligible "dependent" is an employee's lawful spouse or domestic partner; dependent child(ren) of the employee or employee's spouse/domestic partner who are under age 19, or the unmarried child(ren) from the 19th to the 23rd birthday (see note) who qualify as dependents for federal income tax purposes and/or are full-time students or physically or mentally disabled. If you are enrolling a dependent child over the age of 19, please complete a Dependent Verification form and include with this application. Golden West/UniCare requires written proof of student status annually. **Note: Maximum dependent age may vary. Please confirm maximum dependent age with your company's benefits manager.**

If spouse's last name is different from yours, is he/she a domestic partner? ❑ Yes ❑ No

Last Name	First Name	MI	Sex M F	Date of Birth MM/DD/YY	Dentist #	Ortho #	Vision #
Employee				/ /			
Spouse/Domestic Partner				/ /			
Dependent Child #1				/ /			
Dependent Child #2				/ /			
Dependent Child #3				/ /			
Dependent Child #4				/ /			
Dependent Child #5				/ /			

④ **COVERAGE DECLINATION** – ***To be completed only if eligible employee and/or dependent(s) decline or refuse coverage.***

Dental coverage declined for: ❑ Self ❑ Spouse/Domestic Partner ❑ Child(ren)

Reason for declining coverage: ❑ Covered by another group dental plan
Carrier name: _____

❑ Other *(explain)*: _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. I understand that declining coverage at this time, may subject me or my dependent(s) to reduced benefits or a delay in enrollment if I later wish to enroll. I understand that my dependent(s) may be insured under this plan even if they are insured elsewhere.

X_____ _____

Signature if declining coverage for employee/dependent(s) **Date (month/day/year)**

⑤ **AUTHORIZATION** – ***The following Authorization is to be signed by ALL EMPLOYEES applying for coverage.***

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Golden West Dental & Vision obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct any contribution required from my earnings to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Golden West Dental & Vision. Even if this application is approved, any misstatements or omissions may result in future claims being denied and/or the policy being rescinded.

I AM APPLYING FOR PPO COVERAGE: I understand that, if I have applied for PPO coverage, I am responsible for a greater portion of my dental costs when I use a non-participating provider. If a PPO plan is selected and a non-participating provider is used, payments will be based upon covered expense and I will be responsible for any amount over that payment. I am aware that if I am not applying for PPO coverage in a timely manner, I may be subject to reduced benefits or a delay in my effective date.

I AM APPLYING FOR HMO COVERAGE: I understand that, if I have applied for HMO coverage, that I am responsible for paying for services rendered that are not authorized by my selected HMO provider.

I AUTHORIZE: My dental professional, any hospital, clinic, any insurer or employer to give Golden West Dental & Vision information about me. Such information will pertain to my employment, other insurance coverage, or care, advice, treatment or supplies for any physical or medical condition.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security At of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled dependent) and Golden West Dental & Vision, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage both the member/ dependent and Golden West Dental & Vision are giving up the right to have any dispute decided in a court of law before a jury. Golden West and the member and dependents also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

X_____ _____

Signature of Employee **Date (month/day/year)**

HIV Testing Prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health coverage.