# Employee Dental Coverage Application

## for Small Groups (2-50 members) and Large Groups (51+ members)

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

GOLDEN WEST DENTAL & VISION

UNICARE.

**Small Groups**
Fax to: 805-499-0842
Mail to: Golden West Dental & Vision
P.O. Box 9062
Oxnard, CA 93031-9062

**Large Groups**
Fax to: 818-234-4482
Mail to: Golden West Dental & Vision
P.O. Box 629
Woodland Hills, CA 91365

www.goldenwestdental.com

Please complete using black ink/type and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

| Requested effective date | Group no. |
|---|---|
| | |

**SECTION 1: 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, please select a Network General Dentist Provider. If you do not select a provider, one will be selected for you within 30 days of enrollment. | | 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. | | |
| ☐ Preferred Choice<br>☐ 89L2<br>☐ 89L3<br>☐ PA100 | ☐ Preferred Choice/Cosmetic Rider<br>☐ 89L2/Cosmetic Rider<br>☐ 89L3/Cosmetic Rider<br>☐ PA100/Cosmetic Rider | ☐ PPO Plan Nonvoluntary | ☐ Voluntary PPO | High/Low PPO:<br>☐ High Option<br>☐ Low Option |
| HMO members must select a dental office number ► Dental office no. | | GRAY AREAS FOR OFFICE USE ONLY | CPT: _____ months | Date |

*Offered by Golden West Dental & Vision; HMO dental plans are available to California residents only.
**Offered by UniCare Life & Health Insurance Company.

**SECTION 2: PLEASE PROVIDE THE FOLLOWING ENROLLMENT INFORMATION – Must be completed by the employee**

☐ New hire ☐ Part-time to Full-time ☐ Family addition ☐ Change of coverage ☐ Late enrollment ☐ Other: _____

| Cal-COBRA/COBRA applicant type | Cal-COBRA/COBRA effective date | Indicate qualifying event: | | | Date of qualifying event |
|---|---|---|---|---|---|
| ☐ Cal-COBRA ☐ COBRA | | ☐ Termination of employment<br>☐ Reduction of hours . | ☐ Child no longer eligible<br>☐ Divorce/Legal separation | ☐ Death of employee<br>☐ Medicare entitlement | |

| Last name | First name | M.I. | Social Security no. |
|---|---|---|---|
| | | | |

| Home street address (must be complete) | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Mailing street address (if different than above) or P.O. Box Private Mail Box (PMB) no. | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Marital status | No. of dependents including spouse/DP | E-mail address | Home phone no. |
|---|---|---|---|
| ☐ Single ☐ Married<br>☐ Domestic Partner (DP) | | | ( ) |

| Employer name | Occupation/job title (required) | Business phone no. |
|---|---|---|
| | | ( ) |

| Hire date (required) | Employment status (required) | Salary (required) | | No. of hours worked per week (required) |
|---|---|---|---|---|
| | ☐ Part-time ☐ Full-time | $ | ☐ Hourly<br>☐ Weekly<br>☐ Monthly | |

**Language Preference** – When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (optional)
☐ Spanish ☐ Chinese ☐ Korean ☐ Japanese ☐ Tagalog ☐ Vietnamese ☐ Khmer ☐ Hmong ☐ Farsi ☐ Arabic ☐ Armenian ☐ Russian ☐ Other: _____

## SECTION 3. PLEASE TELL US ABOUT YOURSELF AND YOUR ELIGIBLE ENROLLING DEPENDENTS

Eligible dependents include an employee's lawful spouse, or domestic partner, and the enrolled employee's, spouse's or domestic partner's natural child, stepchild, legally adopted child, or child for whom the employee, spouse or domestic partner has been appointed permanent legal guardian by a final court decree or order, up to the child's 26th birthday. Unmarried children age 26 and over may be covered, as specified by the plan certificate or evidence of coverage. Written proof of relationship may be required for certain enrollments. For example, an *existing subscriber* who is initially enrolling a dependent spouse or domestic partner must provide a copy of a Marriage Certificate, Declaration of Domestic Partnership or equivalent document. For enrollment of an adopted child, legal evidence of adoption (or intent to adopt) is required.

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

**FAMILY ADDITION:** Date of marriage or Domestic Partnership Declaration: _____ Date of adoption: _____

| Sex | Last name | First | M.I. | Social Security no. | Birth date | **HMO PLANS ONLY** Choose a dentist for each family member from the Provider Directory which can be found at goldenwestdental.com. |
|---|---|---|---|---|---|---|
| ☐ Male ☐ Female | | | | | | |
| ☐ Male ☐ Female | | | | | | |
| ☐ Male ☐ Female | | | | | | |
| ☐ Male ☐ Female | | | | | | |
| ☐ Male ☐ Female | | | | | | |
| ☐ Male ☐ Female | | | | | | |

**Note:** If any enrolling dependents do not live at the address you listed in Section 2 on the previous page, please provide their addresses on a separate piece of paper stapled to this application.

## SECTION 4. PLEASE COMPLETE IF YOU DO NOT WANT DENTAL COVERAGE FOR YOURSELF AND/OR ANY ELIGIBLE DEPENDENTS

I **do not** want dental coverage for:
- ☐ Myself
- ☐ Spouse/DP
- ☐ Child(ren)

**Reason you do not want dental coverage:** (Proof of coverage will be required.)
- ☐ Covered by another employer-sponsored group plan
  - Carrier name: _____ ID no.: _____
- ☐ Covered by individual policy
  - Carrier name: _____ ID no.: _____
- ☐ Enrolled in any other insurance carrier plan
  - Carrier name: _____ ID no.: _____
- ☐ Other: _____

Names of dependents to be waived: _____

BY WAIVING THIS GROUP DENTAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP DENTAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S DENTAL PLAN UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT)". The twelve (12) month wait will not apply if: (1) I certify at the time of initial enrollment that the coverage under another employer dental benefit plan was the reason for waiving enrollment and I lose coverage under that employer dental benefit plan; (2) my employer offers multiple dental benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

If I waived enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other dental insurance or group dental plan coverage, I must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage). **Please examine your options carefully before waiving this coverage. You should be aware that companies selling individual dental insurance could result in a higher premium.**

| Signature if you do not want coverage for yourself or your dependents | Date |
|---|---|
| **X** | |

## SECTION 5. DENTAL COVERAGE – Please tell us about your current dental coverage

Does any person applying for coverage currently have dental insurance coverage? ☐ Yes ☐ No
If yes, please complete the following.

| Applicant/family member name(s) | Type of coverage: ☐ Group ☐ Individual ☐ Other: _____ | |
|---|---|---|
| Insurance company name | Date coverage began | Date coverage ended |

## SECTION 6. AGREEMENTS AND UNDERSTANDINGS – The following Agreement is to be signed by the EMPLOYEE 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 and/or UniCare Life & Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I work/worked at my 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 any application made by my employer have been accepted and approved by Golden West Dental & Vision and/or UniCare Life & Health Insurance Company.

**I AM APPLYING FOR PPO COVERAGE:** I understand that I am responsible for a greater portion of my dental costs when I use a non-participating provider. Specifically, I may be required to pay higher cost sharing amounts or may have limits on my benefits when using non-participating providers.

**I AM APPLYING FOR HMO COVERAGE:** I understand that I am responsible for paying for services rendered that are not performed by my primary dental provider.

**HIV TESTING PROHIBITED:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

**CANCELLATION OR MODIFICATION OF COVERAGE. PLEASE READ CAREFULLY.**
I attest by signing below that I have reviewed the information provided on this application and accept its provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief and I understand they will be relied upon by Golden West Dental & Vision and/or UniCare Life & Health Insurance Company in accepting this application. I understand that misstatements or failures to report new dental information prior to the effective date may result in a material change or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being cancelled. I understand that Golden West Dental & Vision and/or UniCare Life & Health Insurance Company may cancel any coverage under this application due to any of the following: (a) any material misrepresentation discovered on an application or dental statement; and/or (b) an act of fraud that has been committed.

## PLEASE READ CAREFULLY – Signature required

**REQUIREMENT FOR BINDING ARBITRATION**

YOU AND GOLDEN WEST DENTAL & VISION AND UNICARE LIFE & HEALTH INSURANCE COMPANY AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy and/or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU, GOLDEN WEST DENTAL & VISION AND UNICARE LIFE & HEALTH INSURANCE COMPANY AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND GOLDEN WEST DENTAL & VISION AND/OR UNICARE LIFE & HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

| Employee signature (required) | Date |
|---|---|
| **X** | |

After completion, submit application to the appropriate fax number or mailing address at the top of page one. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.