

APPLICATION FOR ENROLLMENT OR CHANGE INSTRUCTIONS

To elect dental coverage, please fill out the attached form and return it to your Group Official.

APPLICANT INSTRUCTIONS

Complete the following information:

Box #1A - Dental Plan Option

- Check off Dental Option

Box #4 - Coverage Requested

- Check off type of contract

Box #6 A. - Eligible Persons to be Enrolled

- Print last name, first name, middle initial, date of birth, sex, social security number for yourself and each dependent. *If dependent is over contract age, check off reason: student or handicapped.

B. Marital Status of Applicant

- Check off appropriate box

Box #7 - Applicant's Address and Phone Number

- Print complete address and phone number

Box #8 A - E - Other Group Dental Insurance

- Print other group dental insurance information if you or any member of your immediate family have other dental insurance.

Box #9 - For Presently Enrolled Customers Changing Their Coverage

- Enter date of event: Month/Day/Year
- Enter identification number

9A - Adding Dependent(s)

9B - Deleting Dependent(s)

9C - Continuing Coverage under COBRA

- Complete data where applicable

Box #10 - Signature

- Please sign and date the application, return it to your Group Official to complete Sections 2, 3 and 5.

GROUP OFFICIAL INSTRUCTIONS

Complete the following information:

Box #1B - Insurer

- Check off name of Insurer providing benefits.

Box #2A - Group Name

- Print your company's name

2B - Group Number/Sub Group Number

- Enter 7-digit group number

2C - Proposed Effective Date

- Enter applicant's proposed effective date of coverage

2D - Remitting Agent's Signature and Date

- Please sign and date the application

Box #3 - Reason for Application

- Check off the appropriate box

Box #5 - Employment Information

5A - Date of Hire

- Enter month/day/year

5B - Date of Rehire

- Enter month/day/year

5C - Is employee actively at work?

- Enter appropriate information

NOTE: To avoid processing delay, please review the entire application for completeness.

APPLICATION FOR ENROLLMENT OR CHANGE

1A DENTAL PLAN OPTION (Check one Box only)		1B INSURER (Check one Box only)		2 GROUP INFORMATION (Section 1 to be completed by employer.)						
<input type="checkbox"/> Horizon Dental Option <input type="checkbox"/> Horizon Dental PPO <input type="checkbox"/> Horizon Dental PPO Access		<input type="checkbox"/> Horizon Healthcare Insurance Company of Pennsylvania <input type="checkbox"/> Horizon Healthcare Insurance Company of New York		A. Group Name		B. Group No. / Subgroup No.				
				C. Proposed Effective Date		D. Remitting Agent's Signature and Date				
3 REASON FOR APPLICATION				4 COVERAGE REQUESTED						
Please check the appropriate box(es). <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Adding/Deleting Dependents <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Newly Eligible <input type="checkbox"/> Other _____				Please check the appropriate box						
				Type of Contract	Single	Husband and Wife	Family	Parent and Child(ren)		
5 EMPLOYMENT INFORMATION										
A. Date of Hire: Mo. Day Yr.				B. Date of Rehire: Mo. Day Yr.						
C. Is the employee actively at work? If yes, indicate the number of hours worked per week _____ <input type="checkbox"/> yes <input type="checkbox"/> no If no, check the appropriate box: <input type="checkbox"/> Pensioner <input type="checkbox"/> Disabled <input type="checkbox"/> Other (specify) _____										
6 ELIGIBLE PERSONS TO BE ENROLLED										
A. Complete this box for yourself and all dependents enrolling. Attach another application if you have more than four children. (Note: Dependent children are covered under a parent's contract only until they reach contract termination age as specified in the group contract.)										
LAST NAME		FIRST	MI	DATE OF BIRTH			SEX	FULL TIME STUDENT OVER CONTRACT AGE	HANDICAP OVER CONTRACT AGE	SOCIAL SECURITY NUMBER
				MO	DAY	YR	M/F			
Applicant										
Spouse										
Child								*	*	
Child								*	*	
Child								*	*	
Child								*	*	
Legal Ward										
* Verification is required for dependents over contract age for full time students and/or handicap.										
B. MARITAL STATUS OF APPLICANT <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)										
7 APPLICANT'S ADDRESS AND PHONE NUMBER										
Street							Area Code			
City State Zip Code							[] [] [] [] - [] [] [] [] - [] [] [] []			
8 OTHER GROUP DENTAL INSURANCE (Please complete this if you or any member of your immediate family has other dental insurance.)										
A. Name of Policy Holder (Last, First)							B. Policy or Identification Number			
C. Name of other Insurance Company										
D. Address of other Insurance Company										
E. Name and Location (City, State) of Spouse's Employer										
9 FOR PRESENTLY ENROLLED CUSTOMERS CHANGING THEIR COVERAGE (Check reason(s) for change and indicate the date of the event and ID number.)										
DATE OF EVENT			MO	DAY	YR	IDENTIFICATION NO.				
						COPY FROM YOUR ID CARD				
A. ADDING DEPENDENT(S) (Be sure to complete section 6A.) <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Ward <input type="checkbox"/> Spouse's Coverage Terminated <input type="checkbox"/> Child <input type="checkbox"/> Adoption <input type="checkbox"/> Previously Refused/Waived Coverage <input type="checkbox"/> Other (specify) _____										
B. DELETING DEPENDENT(S) <input type="checkbox"/> Divorced/Separation <input type="checkbox"/> Coverage Elsewhere <input type="checkbox"/> Child Reached Termination Age or Married <input type="checkbox"/> Death <input type="checkbox"/> Entered Military <input type="checkbox"/> Other (specify) _____ Names of Dependents Being Deleted: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)										
C. CONTINUING COVERAGE UNDER COBRA <input type="checkbox"/> Spouse of Deceased Employee <input type="checkbox"/> Divorced <input type="checkbox"/> Reduction in hours/no longer meets Group's eligibility requirements <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Employment Terminated <input type="checkbox"/> Disabled <input type="checkbox"/> Dependent Child no longer eligible under terms of employer's health plan										
10 SIGNATURE									FOR PLAN USE ONLY	
I hereby apply to the company identified in Section 1B ("Horizon Healthcare") on behalf of myself and any eligible dependents listed. I understand and agree that any coverage provided pursuant to this application will be at the level of benefits available through arrangements between Horizon Healthcare and my group. I hereby accept responsibility for payment of any portion of the premium, if applicable, which I have agreed to pay through the group. I further acknowledge that coverage shall become effective only if approved by Horizon Healthcare and such services which are rendered on or after the affective date of coverage. I authorize Horizon Healthcare to request information from providers to assist in claims processing and to accept claims submitted electronically by third parties. I certify to the best of my knowledge and belief the information on this application is complete and true. I understand that any claim by me or one of my eligible dependents may be denied and my coverage cancelled without prior written notice if I have included false information. I also understand that such a termination will be retroactive to the effective date of our coverage.									INPUT DATE AND INITIAL	
									VERIFY DATE AND INITIAL	
Signature of Applicant _____ Date _____										
FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.										