



CALIFORNIA DENTAL EMPLOYEE APPLICATION /CHANGE FORM

Group Number

Group Number input box

Dental HMO plans underwritten by Golden West Dental and Vison
All other Dental plans insured by HumanaDental Insurance Company or Humana Insurance Company

Please print using black ink. Attach additional sheets if necessary; sign and date all attachments.

1 Employer Data - Complete with the name and location of the employer company offering benefits.

NAME OF EMPLOYER CITY STATE ZIP CODE

2 Employee Information - Welcome! Please indicate if you are a: [] New Applicant or [] Current Insured/Plan Subscriber

EMPLOYEE/LAST NAME FIRST NAME M.I. SEX SSN BIRTH DATE

EMPLOYEE STREET ADDRESS HOME PHONE () E-MAIL ADDRESS HOME WORK

CITY STATE ZIP DATE OF FULL-TIME EMPLOYMENT/REHIRE

DENTIST NAME* CURRENT PATIENT DENTAL NETWORK* FACILITY #* Y/N

*Complete this section if enrolling in a plan that requires the selection of a Primary Care Dentist. Refer to your Provider Directory.

3 Dependent Information - Please list any dependents to be covered.

Table with 5 columns: NAME/RELATIONSHIP, BIRTH DATE, SEX, DENTIST NAME*, CURRENT PATIENT. Rows include Spouse, Child, and multiple Child entries.

4 Plan Selections

Dental Coverage: [] Employee [] Employee & Child(ren) [] Employee & Spouse [] Family

If you have been given a choice of plans please indicate: Dental Plan

5 Enrollment Questions

- 1. How many hours per week do you work for this employer?
2. If your employer offers coverage to Domestic Partners, please identify the child(ren), if any, of your Domestic Partner as listed in Section 3:
3. Are you or any dependent now disabled or unable to perform normal activities?
4. Within the past 12 months, have you or your dependent(s) had any individual or other group DENTAL coverage?

*CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

6 Waiver - Refusal of Coverage

You must complete the section below only if you are waiving (declining) any of the coverage available to you through your employer. This is to acknowledge that I have been given opportunity to apply for group coverage available to me and my dependents pursuant to state law through the above named employer. I hereby waive insurance coverage for:

Myself: Dental

My Spouse: Dental

Dependent Children: Dental

I decline to apply for group coverage because of: Spousal coverage Other _____

I proclaim that I was not pressured or forced by the employer named above, the writing agent, or Humana Insurance Company, HumanaDental Insurance Company or Humana into waiving (declining) the above noted coverage. I understand that in the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) which may require additional limitations and waiting periods. I also understand that I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana Insurance Company, HumanaDental Insurance Company or Humana. I understand that Humana Insurance Company, HumanaDental Insurance Company and Humana reserves the right to deny coverage with any future application for coverage. I freely and voluntarily waive the above noted coverage.

Date _____ Employee Signature X _____

7 Agreement

I hereby acknowledge that I have read the above statements or that they have been read to me. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the company's other rights or requirements. I hereby agree that no insurance will be effective until the date specified by the company on the certificate of coverage/certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

I understand that if my employer has chosen Domestic Partner coverage, eligibility is subject to submission of the Declaration of Domestic Partnership.

I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice. An Employee Application Change Form should not be submitted more than 60 days prior to the effective date. This document will become a part of the certificate if coverage is approved.

Date _____ Employee Signature X _____