

CITY OF SAN DIEGO DENTAL PLAN

ENROLLMENT/CHANGE FORM

PROGRAM TYPE

<input type="checkbox"/> Concordia Plus – DHMO
<input type="checkbox"/> Concordia Preferred – DPO

- New Enrollment Active
 Change (specify) COBRA
 Add Dependent
 New Address
 Delete Dependent(s)

EFFECTIVE DATE							

ENSOURCE		

GROUP NUMBER					SUB GROUP			
8	3	6	3	0	5			

NOTE: Incomplete information on this form will delay your enrollment. Please print clearly.

Social Security Number		Employee Name (Last, First, Middle Initial)					
Home Address					Home Phone ()		
City			State		Zip		Work Phone ()
Date of Marriage/Registration / /		Marital Status		<input type="checkbox"/> Non-Registered Domestic Partner <input type="checkbox"/> Non-Dependant Domestic Partner			
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Registered Domestic Partner		<input type="checkbox"/> Dependent Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Previous Dental Insurance							
Birth Date / /				Hire Date / /			

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT.

Last Name	First Name	MI	Relationship	Sex	Date of Birth	Social Security	ConcordiaPLUS – DHMO Primary Care Dentist No. (See listing)
Self					/ /	- -	
Dependent					/ /	- -	
Dependent					/ /	- -	
Dependent					/ /	- -	
Dependent					/ /	- -	

IF ANY OF THE CHILDREN LISTED ABOVE ARE HANDICAPPED (H) OR FULL-TIME STUDENTS (S) AGE 23 AND OVER, PLEASE MARK AN "H" OR "S" BESIDE THE DEPENDENT'S NAME.

Important: Do you or your dependent(s) have other Group Dental Coverage? Yes No
If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number

DHMO NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE THE BINDING ARBITRATION SECTION OF YOUR EVIDENCE OF COVERAGE.

Employee's Signature _____ Date: _____