EMPLOYEE ENROLLMENT/CHANGE FORM

Use this form for a new enrollment or a change to an existing enrollment for Dental and Vision Coverages.
Please complete in blue or black ink.
Mail to: Premier Access Membership Accounting, P.O. Box 659020, Sacramento, CA 95865-9020 or fax to: 877.648.7748

Group Number:_____ Effective Date of Enrollment/Change:_____

Dental Coverage: ❑ Yes (indicate coverage type) ❑ PPO[3] ❑ DHMO[4]

❑ No, I do not want this coverage. If you do not want Dental Coverage, please mark all that apply:
- ❑ I am covered under another Dental plan.
- ❑ My spouse/domestic partner is covered under another Dental plan.
- ❑ My dependents are covered under another Dental plan.

Vision Coverage[5]: ❑ Yes

❑ No, I do not want this coverage. If you do not want Vision Coverage, please mark all that apply:
- ❑ I am covered under another Vision plan.
- ❑ My spouse/domestic partner is covered under another Vision plan.
- ❑ My dependents are covered under another Vision plan.

Reason for Enrollment / Change

- ❑ New Enrollment/New Hire
  - ❑ Qualifying Event *(Attach supporting documentation)*
  - ❑ Late Enrollee *(Subject to Late Enrollee Waiting Period)*
- ❑ Add Dependent
  Qualifying Event: _____
  Date of Qualifying Event: _____
- ❑ Change of Address
- ❑ Terminate Coverage, Subscriber & Dependent(s)
  ❑ Dental ❑ Vision
- ❑ Terminate Coverage, Dependent(s) Only
  ❑ Dental ❑ Vision
- ❑ Change in Other Dental Insurance *(Please see reverse side)*
- ❑ Other (*Specify:* _____)

Subscriber (Employee) Information

Social Security Number: _____ Date of Hire: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ E-mail Address: _____

Date of Birth: _____ Sex: ❑ M ❑ F

Employer (Company) Name: _____

Job Title: _____ Division/Class: _____ Hours Worked Per Week: _____

Preferred Spoken Language: _____ Preferred Written Language: _____

Are you married or do you have a spouse/domestic partner? ❑ Yes ❑ No Date of marriage/union: _____ - _____ - _____

Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child(ren): _____ - _____ - _____
_____ - _____ - _____

DHMO *Only*[4]: *Please select a Primary Care Dentist (PCD) from the provider directory for yourself and each of your family members. Fill in the Provider ID number and Office ID number in the appropriate areas. If a selection is not made, a PCD will be assigned for you.*

Employee: Primary Care Dentist Office ID# _____ Primary Care Dentist ID# _____

Dependent Information

- New Enrollment/New Hire: Complete this section for all dependents you are choosing to enroll.
- Coverage Type options limited to the Coverage Type(s) elected by the Subscriber.
- Add Dependent: Complete this section only for the dependents you are adding to your existing enrollment.
- Terminate Dependent Coverage: Complete this section only for dependent(s) you are choosing to terminate.

Relation to Subscriber		Coverage Type	Last Name	First Name & MI	Date of Birth**	Sex (M/F)	Primary Care Dentist Office ID #	Primary Care Dentist ID #
Spouse or Registered Domestic Partner	❑ ADD ❑ DROP	❑ DENTAL ❑ VISION						
Child	❑ ADD ❑ DROP	❑ DENTAL ❑ VISION						
Child	❑ ADD ❑ DROP	❑ DENTAL ❑ VISION						
Child	❑ ADD ❑ DROP	❑ DENTAL ❑ VISION						
Child	❑ ADD ❑ DROP	❑ DENTAL ❑ VISION						
Child	❑ ADD ❑ DROP	❑ DENTAL ❑ VISION						

A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents. Supporting documentation of dependent eligible status must be submitted with this form for dependent children age 19 or over for the enrollment to be processed and claims paid.

To the best of my knowledge and belief, I have answered truthfully and completely the information requested on this application. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if any material misrepresentation is made in this form.

SIGNATURE:

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable plan document.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Premier or its designee has the right to reject your request.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the applicable plan document.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your applicable plan document. State limitations may apply.
- Your coverage will not be effective until approved by Premier or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.
- **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Employee Signature: _____ **Date:** _____

I, on my behalf and on behalf of my dependent(s) on this enrollment application, hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance, or agree that the contributions be added to my dues; (3) state that I became a full-time employee on the date stated on the reverse, and do currently work the number of hours per week stated on the reverse, (4) agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Premier* Certificate of Insurance, (5) agree that if I or my dependents receive dental services after my coverage is terminated or lapses, that I am responsible to reimburse Premier for any unrecovered payments made by Premier for such services, and (6) understand that verification of eligibility by Premier does not guarantee payment of claims and that retroactive eligibility changes supersede verifications of eligibility.

DENTAL RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby authorize Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. If you request, Premier will provide a copy to you of any information it discloses to third parties regarding your dental information. This Dental Release authorization shall remain in effect thirty months from the date the application is signed. This Dental Release authorization solely provides authorization of Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. The dental information is being collected by Premier solely for the specific purpose of premium underwriting.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage, I will inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided.

3 Dental PPO coverage is provided by Premier Access.
4 DHMO coverage is provided by Access Dental Plan in California.
5 The Premier Access Vision Plan is administered by MESVision® and is underwritten by the Gerber Life Insurance Company of White Plains, NY.]
* All references to "Premier Access" herein refer to Premier Access Insurance Company