

Dental / Vision / Chiropractic / Life Enrollment Form

- Form must be Completed in Full, Signed and Dated for processing.
- If you are waiving coverage, you must complete, sign and date waiver on page 4 of this application.
- E-mail address: customerservice@choicebuilder.com

Please select one: New Hire Enrollment New Renewal Enrollment New COBRA Enrollment Qualifying Event

If you are an existing member, and are changing dental plans or adding a plan, please use an Employee "Change Request Form".
 For Primary Dental Office changes only, please contact your dental plan directly.

A. PERSONAL INFORMATION

Company Name <input style="width: 95%;" type="text"/>		Company Phone # (XXX) XXX-XXXX <input style="width: 95%;" type="text"/>						
Employee Job Title <input style="width: 95%;" type="text"/>		Full-Time Employment Date (MM/DD/YYYY) <input style="width: 95%;" type="text"/>						
Gender <input type="checkbox"/> M <input type="checkbox"/> F Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner		Group # <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; text-align: center;">B</td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td></tr></table>		B				
B								
Employee Last Name <input style="width: 95%;" type="text"/>		Employee Social Security # <input style="width: 95%;" type="text"/>						
Employee First Name <input style="width: 95%;" type="text"/>		M.I. <input style="width: 20px;" type="text"/>	Date of Birth (MM/DD/YYYY) <input style="width: 95%;" type="text"/>					
Phone # (XXX) XXX-XXXX <input style="width: 200px;" type="text"/>	E-mail Address <input style="width: 900px;" type="text"/>							
Physical Address (Do not use P.O. Box) <input style="width: 550px;" type="text"/>		Apt. # <input style="width: 60px;" type="text"/>	City <input style="width: 250px;" type="text"/>					
State <input style="width: 50px;" type="text"/>	ZIP Code <input style="width: 100px;" type="text"/>							
Mailing Address (if different from above) <input style="width: 550px;" type="text"/>		Apt. # <input style="width: 60px;" type="text"/>	City <input style="width: 250px;" type="text"/>					
State <input style="width: 50px;" type="text"/>	ZIP Code <input style="width: 100px;" type="text"/>							

B. ENROLLMENT INFORMATION

Complete this section ONLY if you are electing dental, vision and/or chiro for yourself and dependents.

Employee	Spouse/Domestic Partner	Child	Child	Child
Enrolling For? <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
Last Name				
First Name				
Relationship to Employee	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
Social Security #	<small>Social Security # required</small>	<small>Social Security # required</small>	<small>Social Security # required</small>	<small>Social Security # required</small>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	<small>(MM/DD/YYYY)</small>	<small>(MM/DD/YYYY)</small>	<small>(MM/DD/YYYY)</small>	<small>(MM/DD/YYYY)</small>
Disabled? <small>(Complete only if over age 26)</small>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If you are enrolling a disabled dependent you must complete a Disabled Dependent Form. (form can be found on the Choice Builder® website)

COBRA APPLICANTS

Please check COBRA type:

COBRA Cal-COBRA

Indicate Qualifying Event

- | | | |
|--|---|---|
| <input type="checkbox"/> Termination of employment | <input type="checkbox"/> Child no longer eligible | <input type="checkbox"/> Medicare entitlement |
| <input type="checkbox"/> Reduction of hours | <input type="checkbox"/> Divorce/legal separation | <input type="checkbox"/> Death of employee |

Date of Qualifying Event
(MM/DD/YYYY)



C. DENTAL BENEFIT

Select ONE plan (see worksheet for plan availability)

DeltaCare® USA DHMO Gold Silver **OR** PPO Platinum Gold Silver
 (Anthem Blue Cross and Delta Dental PPO Options: Employer Sponsored – Gold and Platinum / Voluntary – Silver)

Select a Dental Office (DHMO ONLY) (If the Dental Office selected is not available or one was not selected, the Dental Office will be assigned.)

	Employee	Spouse/Domestic Partner	Child	Child	Child
Last Name					
First Name					
Dentist Name/Office					
Dentist I.D. #					
Current Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
City					

Check here if you would like your Dental Plan to assign you a Primary Dental Office.
 ➔ To enroll more dependents, complete sections A & B on an additional Enrollment Form.

* If changing dental plans or adding a plan, please select a Primary Dental Office. A Primary Dental Office is not required for PPO benefit plans. If a Primary Dental Office is not contracted with your selected Dental Plan prior to enrolling or if a Primary Dental Office is not listed, one will automatically be assigned to you. For Primary Dental Office changes only, please contact your Dental Plan directly.

D. OPTIONAL BENEFITS - Ask your dental plan administrator if any of the optional benefits below are being offered by your employer

Sections A, B & E of this form must be completed for all Optional Benefits.

Vision: Select ONE plan (see worksheet for plan availability)

Platinum Gold Silver (Silver not available with VSP Voluntary)

CHIROPRACTIC (see worksheet for plan availability)

Check this box to add Voluntary Chiropractic coverage

LIFE

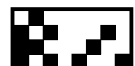
Complete only if your employer has selected life coverage.

Beneficiary Name(s)			Date of Birth <small>(MM/DD/YYYY)</small>	Relationship to You <small>(i.e. spouse, friend, child)</small>	*Percentage	*Type of Beneficiary
Last Name	First Name	M.I.				
			<small>(MM/DD/YYYY)</small>			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
			<small>(MM/DD/YYYY)</small>			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
			<small>(MM/DD/YYYY)</small>			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

* If you are listing more than one primary beneficiary or more than one secondary beneficiary, please enter the percentage of the insurance proceeds that each individual should receive. The percentage of insurance proceeds must equal 100% for each type of beneficiary (primary or secondary). No secondary beneficiaries will be entitled to any part of the insurance proceeds if any primary beneficiary is living at the time of death of the insured.

Premium Only Plan (P.O.P)

I want my portion of eligible insurance premiums paid on a pre-tax basis



E. YOUR LEGAL ACKNOWLEDGEMENT

(Read, sign and date where indicated)

FOR ALL ENROLLEES:

I agree for myself and my dependents to be bound by the benefits, co-pays, deductibles, exclusions, limitations and other terms of the health plan's small group contract as administered by the state of California.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this form, myself and my dependents named on this form.

- I am considered eligible by my employer because I am a full-time employee who works the required number of hours per week.
- If I am an eligible employee applying for coverage outside of a renewal period, I have had a change in family status or have experienced another qualifying event that qualifies either me or my dependent(s) as a "Late enrollee" pursuant to California law.
- I am not a part-time, substitute or temporary employee.
- My children's dates of birth are accurate. My children meet all eligibility requirements. I understand that the preceding statements are subject to audit at any time and agree to provide Choice Builder® with any and all information necessary to prove the above statements.
- I understand that false statements made with the intent to deceive or that materially affects the insurer's acceptance of risk will cause the termination of all Choice Builder benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Choice Builder program providers thereafter. Additionally, the coverage may be cancelled or the employer's contract rescinded.
- I understand that any persons, business or health plan that suffers a loss because of false declarations contained in this statement may take legal action against me to recover their losses.
- I authorize any payroll deduction that may be required towards the cost of this coverage.
- The representations made are the basis upon which coverage may be issued.
- California law prohibits HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
- A policy of group health insurance shall provide equal coverage to employers for the registered domestic partner of an employee, insured, or policyholder to the same extent, and subject to the same terms and conditions, as provided to a spouse of the employee, insured, or policyholder, and shall inform employers of this coverage.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

FOR LANDMARK HEALTHPLAN ENROLLEES ONLY:

Terms and conditions of enrollment are described in your Landmark Health Plan of California, Inc. (the "Plan") Combined Evidence of Coverage and Disclosure Form, and the Group Agreement between the Plan and your Employer Group.

In the event that this application for coverage is accepted, I authorize my health care practitioner, as permitted by law, to provide the Plan with information concerning the health condition or treatment of any enrollee named above, as required for the Plan to authorize or pay for covered services provided by such practitioner.

I further authorize the Plan and any other health care plan through which I and/or my dependents have coverage to release any information to one another that would be necessary to coordinate benefits between or among the plans.

With regard to the authorizations above, I agree that a copy of this form shall be valid as the original.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and Landmark Health Plan of California, Inc., or any of its parents, subsidiaries, or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

My signature acknowledges both my understanding of the information presented above as well as the decision to enroll in the coverage(s) I have selected.

Signature

Print Name

Date (MM/DD/YYYY)

X

YOU MUST COMPLETE SECTIONS A-E IN ORDER FOR YOUR FORM TO BE PROCESSED

9029



DENTAL and/or VISION WAIVER

(for employer sponsored plans only, not required for voluntary plans)

IMPORTANT!

Complete this page only if you **DO NOT WANT DENTAL OR VISION COVERAGE** for yourself and/or your eligible dependents (if offered by your employer). If sponsored by your employer, the life coverage, chiropractic coverage, or chiropractic/acupuncture coverage cannot be waived and you are required to complete a Dental / Vision / Chiropractic / Life Enrollment Form.

Personal Information

Company Name <input style="width: 95%;" type="text"/>	Company Phone # (XXX) XXX-XXXX <input style="width: 95%;" type="text"/>						
Employee Last Name <input style="width: 95%;" type="text"/>	Employee Social Security # <input style="width: 95%;" type="text"/>						
Employee First Name <input style="width: 95%;" type="text"/>	Group # <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">B</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table>	B					
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Type of Waiver

I have been offered coverage by my employer, but at this time I wish to **DECLINE** coverage as follows

- 1) **Dental for** Myself and Dependents Spouse Domestic Partner Child(ren)
- 2) **Vision for** Myself and Dependents Spouse Domestic Partner Child(ren)

Reason

Required only if employee waiving coverage — not required if waiving coverage for dependents only

1) **Reason waiving Dental**

Other Group Coverage Carrier Name _____ Group # _____

Medicare

Medi-cal

Individual Policy

OtherReason _____ (explanation required)

2) **Reason waiving Vision**

Other Group Coverage Carrier Name _____ Group # _____

Medicare

Medi-cal

Individual Policy

OtherReason _____ (explanation required)

Signature

- I understand that by waiving coverage now, Choice Builder® can impose up to a 12 month period of exclusion which would begin at the time of my later decision to elect coverage.
- I also understand that if my employer is sponsoring life coverage, chiropractic coverage, or chiropractic/acupuncture coverage, that I CANNOT waive these coverages. **(Steps A-E MUST be completed if these benefits are being sponsored.)**

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee SIGN HERE TO WAIVE COVERAGE →	Print Name	Date (MM/DD/YYYY)
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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that <u>MUST</u> be met
<p>New Spouse/ New Stepchild</p>	<p>If marriage occurred before the 16th of the month, coverage begins on the first day of the month of the date of marriage.</p> <p>If marriage occurred on the 16th of the month or after, coverage begins on the first of month <u>following</u> date of marriage.</p>	<ul style="list-style-type: none"> ■ New spouse must be legally married to the employee ■ New stepchild must also meet the dependent children requirements listed below
<p>Birth/Adoption/ Adopted Child, Non-Temporary Legal Ward, and Dependent Child</p>	<p>If birth/date of placement occurred before the 16th of the month, coverage begins on the first day of the month of the date of birth/placement.</p> <p>If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the first of the <u>following</u> month. Coverage for the dependent begins on the first of the month following the birth/date of placement.</p>	<ul style="list-style-type: none"> ■ Born to, a stepchild or legal ward of, adopted by eligible employee, employee spouse or domestic partner ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) <p>Disabled Dependents: Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday.</p> <div style="background-color: black; color: white; text-align: center; padding: 5px;"> <p>Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p> </div>
<p>Domestic Partner/ Child of Domestic Partner</p>	<p><u>During Initial Enrollment or Group's Annual Renewal:</u> Coverage begins on group's effective date.</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month.</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a domestic partner will require a state-stamped copy of the Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue or a signed affidavit for opposite sex and over age 62 domestic partnerships. If domestic partnership established before the 16th of the month, coverage begins on the first day of the month of the date of event. If domestic partnership established on the 16th of the month or after, coverage begins on the first of month following date of event.</p>	<p><u>For a Domestic Partner to qualify, Employee and Domestic Partner must:</u></p> <ul style="list-style-type: none"> ■ Neither is married under either statutory, common law or part of another domestic partnership ■ Both be 18 years of age or older; or if under 18, have a valid court order allowing partnership ■ Share an intimate and committed relationship ■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship ■ Both be mentally competent ■ Not related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify Choice Builder® immediately upon termination of domestic partnership <p><u>Children of Domestic Partner must also meet the dependent children requirements listed above</u></p> <p>Members who are in a same sex partnership or are the opposite sex and over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership.</p> <div style="background-color: black; color: white; text-align: center; padding: 5px;"> <p>Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment</p> </div>

