

# Member Enrollment/ Change of Status

**PacifiCare**<sup>®</sup>  
Dental of Colorado

PacifiCare Dental of Colorado  
Post Office Box 6975  
Englewood, CO 80155-6975

**FOR PACIFICARE DENTAL USE ONLY**

Coverage Approved  
 Coverage Denied

Group No.

Tier

Effective Date

**IMPORTANT: See other side for instructions. Please complete all sections. This form cannot be processed if information is incomplete.**

<p><b>New Enrollment</b></p> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <hr/> <input type="checkbox"/> Change of Status	<p><b>Change of Status</b></p> <input type="checkbox"/> Name Change <input type="checkbox"/> Provider Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change <input type="checkbox"/> Plan Change (from PPO to HMO) <input type="checkbox"/> Dependent Change (Add or Remove)	<p><b>Dependent Change</b> <i>Must be submitted to PDVA within 31 days of event</i></p> <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption/Placement <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other _____
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**SUBSCRIBER** Please complete all sections. This form cannot be processed if information is incomplete.

Add  Remove

Employee last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of hire \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex  M  F Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social security number \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

Dental HMO facility number \_\_\_\_\_ Dentist's name/city \_\_\_\_\_ Have you received treatment from this dentist?  
 Yes  No

**DEPENDENTS** Please complete all sections. This form cannot be processed if information is incomplete.

**1**  Add  Remove Relationship (*spouse, daughter, son*) \_\_\_\_\_ Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Sex  M  F Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social security number \_\_\_\_\_ Is dependent a student over age 19? (*proof must be submitted*)  
 Yes  No

Dental HMO facility number \_\_\_\_\_ Dentist's name/city \_\_\_\_\_ Have you received treatment from this dentist?  
 Yes  No

**2**  Add  Remove Relationship (*spouse, daughter, son*) \_\_\_\_\_ Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Sex  M  F Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social security number \_\_\_\_\_ Is dependent a student over age 19? (*proof must be submitted*)  
 Yes  No

Dental HMO facility number \_\_\_\_\_ Dentist's name/city \_\_\_\_\_ Have you received treatment from this dentist?  
 Yes  No

**3**  Add  Remove Relationship (*spouse, daughter, son*) \_\_\_\_\_ Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Sex  M  F Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social security number \_\_\_\_\_ Is dependent a student over age 19? (*proof must be submitted*)  
 Yes  No

Dental HMO facility number \_\_\_\_\_ Dentist's name/city \_\_\_\_\_ Have you received treatment from this dentist?  
 Yes  No

**4**  Add  Remove Relationship (*spouse, daughter, son*) \_\_\_\_\_ Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Sex  M  F Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social security number \_\_\_\_\_ Is dependent a student over age 19? (*proof must be submitted*)  
 Yes  No

Dental HMO facility number \_\_\_\_\_ Dentist's name/city \_\_\_\_\_ Have you received treatment from this dentist?  
 Yes  No

**PLAN SELECTION** Please complete all sections. This form cannot be processed if information is incomplete.

Please mark the plan in which you are enrolling:

Dental HMO  Dental Indemnity\*  Dental PPO\*  Other \_\_\_\_\_  No Dental  
 Orthodontic Plan A\* (optional rider)  Orthodontic Plan B\* (optional rider)  Orthodontic Plan C\* (optional rider)  No Ortho

Spouse's insurance carrier (*if applicable*) \_\_\_\_\_

I understand and agree to the terms and conditions on the reverse side of this sheet.

**X** \_\_\_\_\_  
Employee Signature Date

**EMPLOYER USE ONLY**

Company name \_\_\_\_\_ Group number \_\_\_\_\_

Plan name \_\_\_\_\_ Enrollee's effective date of coverage \_\_\_\_\_

\* Underwritten by PacifiCare Life Assurance Company in all states except California where underwritten by PacifiCare Life & Health Ins. Co., Inc. #CO-435 (R1/02)

## Membership Conditions

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I am aware of and accept the following PacifiCare Dental membership conditions:

- 1) I (we) have chosen a participating primary care dentist (PCD) as have my (our dependents, (if any)).
- 2) I (we) understand that each member (subscriber or dependent) will not receive an I.D. card nor have access to any benefits except for emergency care until a primary care dentist has been selected.
- 3) I (we) will use the primary care dentist to provide or arrange for all necessary dental care (except for out-of area emergencies). I (we) may change primary care dentists only by contacting the PacifiCare Dental office and arranging for a transfer.
- 4) I (we) authorize the release of all of my (our) dental records to PacifiCare Dental or its authorized agents for the performance of any one or more of the following: a) the administration of the Agreement; b) dental research and education sanctioned by PacifiCare Dental; c) peer review for quality assurance and utilization review by PacifiCare Dental or its authorized agents; d) creation and provision of statistical utilization data to the subscribing group; e) bona fide dental emergencies; and f) any other exceptions provided by law. Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released.
- 5) I (we) will abide by the master contract applicable to the plan in which I (we) enrolled.
- 6) I (we) will cooperate as required in the general Coordination of Benefits and the Subrogation provisions of the master contract.
- 7) I (we) authorize necessary payroll deductions, if any, by my (our) employer to cover the cost of my (our) PacifiCare Dental membership.
- 8) I (we) understand that my (our) identification cards are for identification only. The dates which may appear on the card reflect the effective date of the plan contract for which I (we) have enrolled, not necessarily my (our) dates of eligibility.
- 9) I (we) understand that by choosing the coverage specified in the Evidence of Coverage (EOC), paying the premium, or accepting benefits in the EOC, I (we) or my (our) legal representative expressly agree to all terms, conditions and provisions of the EOC.
- 10) I (we) understand that as a member of a Prepaid PacifiCare Dental Plan, I (we) must select a primary care dental office and have so chosen (as have my (our) dependents, if any) from the PacifiCare Dental Provider Directory,
- 11) I (we) understand that as a member of a PacifiCare PPO Dental Plan, I (we) will need to receive care from a PacifiCare Preferred Participating Provider dental office in order to be eligible for the in-network benefit. I (we) may choose from dental offices listed in the PacifiCare Preferred Provider Dental Directory.
- 12) I (we) understand that dental provider offices listed in both the Prepaid Dental Care Plan Dental Provider Directory and the PacifiCare Preferred Provider Dental Directory are subject to change.

## Instructions

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- 1) Please use pen, print clearly and press hard.
- 2) Complete all the information requested.
- 3) Be sure to select a primary care dentist (PCD) for each covered member of your family. If desired, each family member may have a different PCD (Participating PCDs are listed on the PacifiCare Dental Provider Directory.) Prepaid Dental Care members only.
- 4) Sign and date the form, keep the pink copy for your records, and forward the other copies to your personnel office.

## Remember

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Notify your employer promptly if any change in the status of your family that affects your coverage.

Call the PacifiCare Dental Customer Service department if you your address changes or if you wish to change your primary care dentist. Primary care dentist changes will become effective on the first day of the following month.

If you or any covered member of your family becomes ineligible to continue coverage under this plan, notify your employer.

Important information on how to use PacifiCare Dental will be sent to you with your PacifiCare Dental identification card.

## Your PCD

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PacifiCare Dental members are most satisfied with their primary care dentist (PCD) when...

- they ask their family and friends to make recommendations.
- they choose a primary care dentist who is close to their home or work so dentist visits are convenient.
- they visit or phone the doctor's office and talk with a staff member about such things as the office, office hours and parking.
- they find out more about the doctor, especially if they have a preference in a particular area, like age, years in practice, specialized training or board certification.

The importance of having a PacifiCare Dental primary care dentist:

- A dentist who serves as your personal health-care manager, helping you get the most appropriate care at the most appropriate time.
- A dentist with whom you can develop a mutually satisfying relationship built on trust; establishing a rapport can promote consistency in your dental treatment.
- A dentist who deals directly with PacifiCare Dental; that's why members don't fill out claim forms.
- A dentist who is familiar with your complete health history.

It is unlawful to knowingly provide false; incomplete, or misleading facts or information to a Prepaid Dental Care Plan for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of benefits, and civil damages. Any Prepaid Dental Care Plan or agent of a Prepaid Dental Care Plan who knowingly provides false, incomplete, or misleading facts or information to a plan member or claimant for the purpose of defrauding or attempting to defraud the plan member or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.