

UNITED CONCORDIA DENTAL PLANS, INC. is a wholly owned subsidiary of United Concordia Companies, Inc.

1. SUBSCRIBER INFORMATION

Last Name:		First Name:		M.I.	SS#
Street:			Apt.	Date Employed:	
City:		State:	Zip:	Employment: ___ Active ___ Retired	
Sex:	Date of Birth: / /	Work Phone: ()		Federal Agency:	

2. COVERAGE SELECTION: ___ Member Only ___ Member & Spouse ___ Family ___ Member & Child
CHOOSE A PAYMENT MODE: ___ Bi-Weekly ___ Mo ___ Qtr

3. GENERAL INFORMATION

4. DENTAL FACILITY SELECTION

Last Name	First Name	MI	Social Security #	Relationship	Date of Birth	Dental Facility Name	Dentist Provider Code
				SELF			
				SPOUSE			
				CHILD: ___M ___F			
				CHILD: ___M ___F			
				CHILD: ___M ___F			
				CHILD: ___M ___F			

5. DETAILED DEPENDENT INFORMATION

Are any of your dependents covered by Medicare? ___ No ___ Yes	Dependent Name:
ARE ANY OF YOUR DEPENDENTS DISABLED?: (A) Name:	Date of disability:
Full-time Students (19 & over)? (A) Name: _____	Exp. Grad. Date: _____
School Name:	

6. OTHER INSURANCE INFORMATION

Do You or your dependents have any other dental insurance policy? ___ Yes ___ No	If yes: Name of Person(s) covered:
Name of Spouse=s employer:	Business Phone of Spouse: ()

CONDITIONS OF ENROLLMENT

I hereby apply for the type of coverage checked above for myself and on behalf of my dependents listed on the application, if any, who are eligible according to the terms of the contract between UNITED CONCORDIA (AUC@), and my organization. I agree to pay all premiums billed and authorize my employer, when applicable, to deduct from my earnings the amount required to cover my share of the premiums. I understand that this application of a Group Certificate is subject to acceptance by UC. If accepted I agree for myself and my dependents to the following:

1. to be bound by the benefits, copayments, limitations, exclusions and other terms of the Dental Plan Organization Certificate issued to me (hereinafter called the Certificate) and as such Certificate may be modified in writing.
2. to contact the participating Dentist selected by me and my dependents, if any, to provide or arrange for all Dental Benefits. Furthermore, I agree and understand that all services that all services must be obtained from Participating Dentists and Specialists unless I have the Point of Service Rider or the situation is an accident or emergency occurring 50 miles or more from home.
3. to authorize any persons who shall have rendered services to me or my dependents, if any, under the Certificate to make available to UC any photographs, records, molds, or information regarding such services, if required, by UC. Such information may also be released to persons or entities which at the direction of UC are conducting administrative services review of the cost, quality and/or the appropriateness of service rendered to persons in UC.

I hereby certify that I am the spouse, parent, or legal guardian of the dependents shown above, if any and that they are domiciled with me. I hereby represent to you that all information furnished by me herein is true and complete to the best of my knowledge and shall be deemed to be representative upon all rights under the Certificate are conditioned. I and my dependents, if any, understand that the Participating Dentists and specialists are independent contractors for the sole purpose of providing Dental Benefits under this Certificate for UC Subscribers and as such, are not employees, agents or representatives of UC.

 Signature of Applicant Date
 FORM 10-305 MD 1296