

### Dental Enrollment Form

1. Member Information						
Last Name		First Name		Rank	TAX ID	
Address		City		State	Zip Code	
Home/Cell Phone		Email		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Status Please check one: <input type="checkbox"/> Active <input type="checkbox"/> Retired	
2. Dental Plan Selection						
<input type="checkbox"/> <b>UHC PPO 10</b> (SOC's Premium Free Default Plan)		<input type="checkbox"/> <b>SOC BUY-UP PLAN</b> ( Member Cost Share Plan) <b>Members who are currently enrolled in the SOC Buy-Up plan and wish to continue with that plan must choose this plan.</b> Please check one: <input type="checkbox"/> Active \$24.50 Bi-weekly Payroll Deduction <input type="checkbox"/> Retired \$49.00 Monthly Pension Deduction			<input type="checkbox"/> <b>UHC DHMO</b> (Premium Free Managed Care Plan)	
Considerations UHC PPO 10		Considerations SOC Buy-Up Plan			Considerations DHMO	
<ul style="list-style-type: none"> <li>• Large Network of Providers</li> <li>• Co-pays for many services</li> <li>• Minimal out of network reimbursement</li> <li>• <b>\$2000 annual family maximum</b></li> </ul>		<ul style="list-style-type: none"> <li>• <b>Largest National Provider Network</b></li> <li>• No co-pays for covered preventive, basic and major services</li> <li>• Cost share plan, member has monthly premiums.</li> <li>• Highest out of network reimbursement</li> <li>• This plan includes a reduced rate for covered implant services. Patient is responsible for 100% of these reduced rates.</li> <li>• <b>Annual maximum of \$3000 per individual</b></li> </ul>			<ul style="list-style-type: none"> <li>• Extensive number of procedures covered with no co-pays.</li> <li>• Implant coverage available-with co-pays</li> <li>• Smallest provider network</li> <li>• No out of network reimbursements</li> <li>• <b>No annual maximum</b></li> </ul>	
3. Dependent(s)						
Last Name	First Name	Relationship	Sex	DOB		
				Month	Day	Year
_____			_____			
Member Signature			MM/DD/YYYY			