

Dental Enrollment/Change 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"/> UHC PPO 10 (SOC's Premium Free Default Plan)	<input type="checkbox"/> CAREINGTON BUY-UP PLAN (Member Cost Share Plan) 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"/> UHC DHMO (Premium Free Managed Care Plan)		
Considerations UHC PPO 10	Considerations Careington Buy-Up Plan			Considerations DHMO		
<ul style="list-style-type: none"> Large Network of Providers Co-pays for many services Minimal out of network reimbursement \$2000 annual family maximum 	<ul style="list-style-type: none"> Largest National Provider Network No co-pays for covered preventive, basic and major services Cost share plan, member has monthly premiums. Highest out of network reimbursement This plan includes a reduced rate for covered implant services. Patient is responsible for 100% of these reduced rates. Annual maximum of \$3000 per individual 			<ul style="list-style-type: none"> Extensive number of procedures covered with no co-pays. Implant coverage available-with co-pays Smallest provider network No out of network reimbursements No annual maximum 		
3. Dependent(s)						
Last Name	First Name	Relationship	Sex	DOB		
				Month	Day	Year
_____			_____			
Member Signature			MM/DD/YYYY			