UnitedHealthcare®

ROCKY MOUNTAIN HEALTH PLANS®

9M

Employee – Dental Enrollment/Change Form

Please complete the information below if your employer is offering Dental coverage with your Rocky Mountain Health Plans medical coverage.

Name of Employer Group:

Employee Information

Last Name:		First Name:		
Date of Birth: / /	Gender: ☐ M ☐ F	Are you married? ☐ Yes ☐ No	Social Security Number:	Date of Hire: / /
Home Address:		City, State:		Zipcode:

Enrollment

☐ Yes, I am enrolling in Voluntary Dental coverage, in addition to the medical.

☐ Yes, I am enrolling in Voluntary Dental coverage and waiving enrollment in the medical plan.

Coverage requested for: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren)* ☐ Employee + Family

☐ I have listed dependents enrolling in the Dental Plan below.

Spouse Name	Gender	Birthdate	Social Security Number

Dependent Name	Gender	Birthdate	Relationship to Employee
		/ /	
		/ /	
		/ /	
		/ /	

Waiver

☐ I am waiving dental coverage. I understand I am also waiving dental coverage for any eligible dependents and my next opportunity to enroll in the dental plan will be Open Enrollment.

Add/Drop Information

I understand that if I drop dental coverage for myself, all covered family members will be disenrolled.

Reason for addition of dependent:
☐ Marriage ☐ Newborn or adopted child ☐ Employer group open enrollment ☐ Dependent lost other dental coverage

Add	Drop	Date	Last Name	First Name	MI	Sex M/F	Date of Birth mm/dd/yyyy	Relationship to Subscriber

I agree that enrollment, eligibility, coverage and benefits of the dental plan are subject to applicable policies and to all terms of the applicable coverage policy.

Signature: **Date:**