



# Regence

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

100 SW Market Street  
P.O. Box 1271 E-3A  
Portland, OR 97207-1271  
(503) 721-7161 • (800) 794-5390

## GROUP MANAGED CARE DENTAL INSURANCE EMPLOYEE ENROLLMENT FORM

Please complete all information on this page and on page 2.

<b>EMPLOYER NAME</b>				
<input type="checkbox"/> New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____		<input type="checkbox"/> Change of Existing Enrollment		
Employee's Last Name	Employee's First Name	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
Social Security Number	<input type="checkbox"/> Married / Domestic Partner (Spouse) <input type="checkbox"/> Divorced <input type="checkbox"/> Single		Telephone Number (    )	
Home Address & Apt. No./Mailing Address		City	State	Zip

**Dependents to be enrolled:** Dependent children must be under 26 years of age.

Last Name	First Name	M	SS#	Birth Date	Sex	Relationship (Spouse, Child)
					M / F	
					M / F	
					M / F	
					M / F	
					M / F	

List names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

If changing existing enrollment, indicate reason below:

<input type="checkbox"/> Name Change – Former name _____	<input type="checkbox"/> Address Change
<input type="checkbox"/> Add Dependent(s) due to:	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage / Domestic Partnership – Date _____
<input type="checkbox"/> Newborn - Date of Birth _____	<input type="checkbox"/> Adoption - Date of Placement in Home _____
<input type="checkbox"/> Loss of Coverage - Date _____	Reason _____
Name of Prior Carrier _____	Telephone Number _____
Coverage was <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Prior Policy Number _____
Coverage was for <input type="checkbox"/> Self Only <input type="checkbox"/> Family as listed above <input type="checkbox"/> Other	Identification Number _____
<input type="checkbox"/> Delete Dependent(s) – Reason _____	
Name(s) _____	
If applicable – Final date of Divorce / Termination of Domestic Partnership _____	



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I hereby apply for enrollment with Regence Life and Health Insurance Company under the Group Voluntary Dental Insurance Policy of the Employer named on Page 1. I hereby authorize the Employer named on Page 1 to withhold insurance premiums, if required, from my paycheck and to pay them directly to Regence Life and Health Insurance Company.

I acknowledge and understand Regence Life and Health Insurance Company may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statement, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

**INSURANCE FRAUD WARNING:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all coverage under this Policy will terminate for such Member retroactively to the Effective Date.

▶ \_\_\_\_\_  
Employee's Full Name (please print clearly)

▶ \_\_\_\_\_  
Employee's Signature

▶ \_\_\_\_\_  
Date Signed