EMPLOYEE ENROLLMENT/CHANGE FORM

Use this form for a new enrollment or a change to an existing enrollment. Please complete in blue or black ink.
Mail to: Premier Access Membership Accounting, P.O. Box 659020, Sacramento, CA 95865-9020 or fax to: 877.648.7748

Group Number: 3815 Coverage Type: ❑ PPO ❑ DHMO

Effective Date of Enrollment/Change: 01/01/2021

Reason for Enrollment Form

❑ New Enrollment/New Hire
- ❑ Qualifying Event *(Attach supporting documentation)*
- ❑ Late Enrollee *(Subject to Late Enrollee Waiting Period)*

❑ Add Dependent (including spouse and registered domestic partner)

Qualifying Event: ______________________

Date of Qualifying Event: ______________________

❑ Change of Address

❑ Terminate Dental Coverage, Subscriber & Dependent(s)

❑ Terminate Dental Coverage, Dependent(s) Only

❑ Change in Other Dental Insurance *(Please see reverse side)*

❑X Other (*Specify:* Open Enrollment ______________________)

Subscriber (Employee) Information

Social Security Number: ______________________ Date of Hire: ______________________

Last Name: ______________________ First Name: ______________________ MI: __________

Street Address: ______________________

City: ______________________ State: ______________ Zip: ______________

Home Phone: (________) ______________________ E-mail Address: ______________________

Date of Birth: ______________ Sex: ❑ M ❑ F Married? ❑ Yes ❑ No Children? ❑ Yes ❑ No

Employer (Company) Name: ______________________

Job Title: ______________ Division/Class: ______________ Hours Worked Per Week: ______________

Preferred Spoken Language: ______________________ Preferred Written Language: ______________________

Ethnicity (optional): ______________________ Race (optional): ______________________

DHMO Only: Please select a Primary Care Dentist (PCD) from the provider directory for yourself and each of your family members. Fill in the Provider ID number and Office ID number in the appropriate areas. If a selection is not made, a PCD will be assigned for you.

Primary Care Dentist No. ______________________ Primary Care Dentist Office No. ______________________

Dependent Information

New Enrollment/New Hire: Complete this section for all dependents you are choosing to enroll.
Add Dependent: Complete this section only for the dependents you are adding to your existing enrollment.
Terminate Dependent Coverage Only: Complete this section only for dependent(s) you are choosing to terminate.

Relation to Subscriber	Last Name	First Name & MI	Date of Birth**	Sex (M/F)	Primary Care Dentist Office ID #	Primary Care Dentist ID #
Spouse/ or Reg. Domestic Partner						
Child						
Child						
Child						
Child						
Child						

** Dependent child eligibility requirements are defined by the Employer Group Policy. Supporting documentation of dependent eligible status must be submitted with this form for dependent children age 19 or over for the enrollment to be processed and claims paid.

To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this application, including the information on the back of this application. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment application. I have read and agree to the notice on the back of this form.

MANDATORY BINDING ARBITRATION: Premier Access Insurance Company uses binding arbitration to settle disputes, including to settle claims of dental malpractice. The insured understands and agrees that if a dispute arises in connection with this policy, the parties waive the right to a jury trial and must settle the dispute through binding arbitration. The Premier Certificate of Insurance contains a provision that further addresses this issue Premier Access Insurance Company does not use binding arbitration in connection with any dispute that an insured's life insurance coverage.

Employee Signature: ______________________ **Date:** ______________