What works for you?℠

UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare Dental Enrollment Form

SOCIAL SECURITY NUMBER	NAME, LAST	FIRST	MI

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER	
Home ( ) Work ( )	[ ] Male [ ] Female [ ] Single [ ] Married

APPLICANT'S DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN COVERAGE ☐ Single ☐ Single + Spouse ☐ Single + Child(ren) ☐ Family

☐ UnitedHealthcare Dental Options PPO Plan

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name	Initial	Last Name (If different)	Date of Birth (Mo/Day/Yr)	Relationship	
				[ ] Husband	[ ] Wife
				[ ] Son	[ ] Daughter
				[ ] Son	[ ] Daughter
				[ ] Son	[ ] Daughter
				[ ] Son	[ ] Daughter

FOR INTERNAL USE ONLY

Employer Authorization
Effective date
Type of coverage

SIGNATURE _____

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement

MINIMUM ENROLLMENT IS ONE YEAR

The UnitedHealthcare Dental Managed Indemnity Plan and the UnitedHealthcare Dental Options PPO Plan are underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York) United HealthCare Insurance Company of New York, Hauppauge, New York (New York only)

100-2659 1/00
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White: UHC copy Yellow: Applicant copy