The Dental Care PLUS GROUP
A DentaQuest Company

Dental Care Plus, Inc.
100 Crowne Point Place • Cincinnati, OH 45241
Phone (513) 554-1100 • 1-800-367-9466

☐ **DHMO**

☐ **DPPO-DENTASELECT**

ALL SECTIONS MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED.

ENROLLMENT FORM

DENTAL GROUP NUMBER			EFFECTIVE DATE	
SOCIAL SECURITY NUMBER – –	**EMPLOYER AND LOCATION**			
EMPLOYEE LAST NAME FIRST NAME MI			EMPLOYEE'S HOME PHONE	
			EMPLOYEE'S EMAIL ADDRESS	
HOME ADDRESS		APT#	GENDER	DATE OF BIRTH
CITY	STATE	ZIP CODE	COUNTY IN WHICH YOU RESIDE	
MARITAL STATUS: ☐ SINGLE (01) ☐ MARRIED (02)			EMPLOYMENT DATE	

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE COVERED BY THE PLAN

NAME – IF LAST NAME DIFFERENT FROM ABOVE INDICATE LAST NAME	RELATIONSHIP	GENDER	BIRTH DATE	PLAN DENTAL
	SPOUSE			

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:_____

REFUSAL/WAIVER – COMPLETE ONLY IF YOU ARE DECLINING COVERAGE

I DECLINE ALL COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN

REASON FOR REFUSAL: _____

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Policy/Contract issued to my employer by Dental Care Plus, Inc. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Policy/Contract and any changes provided for therein. I understand that certain services may require copayment or deductible, payable by me (or my dependents) directly to the provider of such services. I authorize my employer to deduct the necessary contributions, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan, and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation.

I hereby waive the provider-patient privilege and authorize any provider of dental or vision services to give Dental Care Plus, Inc., its agents and representatives any information concerning the claims for reimbursement for covered services of any person included under such coverage, including the undersigned, the undersigned's spouse and the undersigned's dependents.

To the best of my knowledge, the above information is complete, true, and correct. In the absence of fraud, however, all statements made by applicants or by an insured person shall be deemed representations and not warranties.

PLEASE SIGN WHETHER YOU ARE ACCEPTING OR DECLINING COVERAGE

EMPLOYEE SIGNATURE _____ **DATE** _____

Fraud Notice – Michigan and Ohio Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud Notice – Kentucky Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Fraud Notice – Indiana Residents Only: Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

Fraud Notice – Tennessee Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.