PIBT | PRINTING INDUSTRIES BENEFIT TRUST

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DENTAL ENROLLMENT/ CHANGE FORM

Plan Selected

- ❑ Blue Shield DMO 252 — Facility Choice:_______
- ❑ Western Dental DMO 7750 — Facility Choice:_______
- ❑ Western Dental DMO 7740 — Facility Choice:_______
- ❑ CIGNA DMO F1-07 — Facility Choice:_______
- ❑ Humana Preferred Choice DMO — Facility Choice:_______
- ❑ Humana DPO Indemnity Plan

IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

SECTION 1 EMPLOYER TO COMPLETE THIS SECTION

Company Name	Phone ( )	**FOR PIBT USE ONLY**
Address		GROUP #

New Enrollment ❑ Change ❑
Changes (*Check appropriate boxes*)
❑ Add dependents - Complete Section 3
❑ Name change - Complete Sections 2 and 3

Additions or Changes of Coverage: Report all additions or changes of group coverage to PIBT no later than the 20th day of the month in which it is effective.

COVERAGE EFFECTIVE DATE

PRE-EXISTING CONDITION WAIVED ❑ Yes ❑ No

PIBT ACCOUNT NO.

SECTION 2 EMPLOYEE INFORMATION

Last Name		First Name		M.I.	❑ Single ❑ Married *Date of Marriage*____________
Social Security Number	Full Time Hire Date	Employment Status ❑ Salaried ❑ Hourly	Job Title		❑ Domestic Partner *Registration Date*____________
Residence Mailing Address (Number, Street, Apartment)		City		State	Zip
Home Telephone ( )	Mobile Phone Number ( )	☐ PLEASE CHECK HERE IF YOU ARE CURRENTLY A PATIENT AT THE DENTAL OFFICE YOU HAVE SELECTED			

NOTE: An eligible dependent child is an employee's or spouse's child under the age of 26.

SECTION 3 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION

Name (*Last* / *First* / *M. I.*)	Birthdate *MM/DD/YYYY*	Sex	Choose a Dental Office name and Facility # for each person
Employee	*Birthdate*	F ❑ M ❑	*Dental Office Name*
SS # — —	*Relationship* Self		*Facility #*
Spouse Date of Marriage	*Birthdate*	F ❑ M ❑	*Dental Office Name*
SS # — —	*Relationship* Spouse		*Facility #*
*First dependent**	*Birthdate*	F ❑ M ❑	*Dental Office Name*
SS # — —	*Relationship*		*Facility #*
*Second dependent**	*Birthdate*	F ❑ M ❑	*Dental Office Name*
SS # — —	*Relationship*		*Facility #*
*Third dependent**	*Birthdate*	F ❑ M ❑	*Dental Office Name*
SS # — —	*Relationship*		*Facility #*
*Fourth dependent**	*Birthdate*	F ❑ M ❑	*Dental Office Name*
SS # — —	*Relationship*		*Facility #*

SIGNATURE **DATE**

I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverages as indicated on this form. I authorize the deduction from my earnings of the required contributions, if any, toward the cost of the coverage. I authorize payment of dental benefits to the provider of dental care.

PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage.

I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.

I authorize payment of benefits to the Participating Provider of the benefits.

I authorize any Provider, Insurance Company, Employer or Organization to release any information, on me or my dependents, regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this Plan.

I authorize that payment be made under Part B of Medicare to participating provider for medical and other services furnished me for which it pays or has paid, if applicable.

I understand that any controversy between any Member and Printing Industries Benefit Trust (including its agents, staff physicians and employees) and its providers involving a claim in tort, contract or otherwise, is subject to binding arbitration. (Applicable only to CA residents.)

I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform Printing Industries Benefit Trust and will execute such assignments, liens, or other documents which may be necessary to enable the plan to recover the value of the services provided. I further agree that in the event I or any of dependents collect benefits or damages from any other party who has primary responsibility for services provided by the plan, I will immediately reimburse the plan to the extent of services provided, to the extent permitted by state law.

EMPLOYEE

- Do not complete employer section.
- Complete the EMPLOYEE section, making sure that your Social Security Number is correct when you enroll and whenever you make a change.
- Complete the entire DEPENDENT section if you want your dependents (spouse or children) to be covered under your plan.
- Always sign and date the form.
- Return the completed form to your employer when you are done.

EMPLOYER

- Complete employer section.
- Check that the employee has completed the EMPLOYEE section.
- Be sure that the form is signed and dated.

LATE ENROLLMENT

- Late enrollment for other than specific instances will not be approved onto the plan until open enrollment. Please contact Printing Industries Benefit Trust for further information.