

DENTAL ENROLLMENT/ CHANGE FORM

Plan Selected

- | | |
|--|------------------------|
| <input type="checkbox"/> Blue Shield DMO 252 | Facility Choice: _____ |
| <input type="checkbox"/> Western Dental DMO 7750 | Facility Choice: _____ |
| <input type="checkbox"/> Western Dental DMO 7740 | Facility Choice: _____ |
| <input type="checkbox"/> CIGNA DMO W1-07 | Facility Choice: _____ |
| <input type="checkbox"/> Humana Preferred Choice DMO | Facility Choice: _____ |
| <input type="checkbox"/> 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 <input type="checkbox"/> Change <input type="checkbox"/> Changes (Check appropriate boxes) <input type="checkbox"/> Add dependents - Complete Section 3 <input type="checkbox"/> Name change - Complete Sections 2 and 3		COVERAGE EFFECTIVE DATE PRE-EXISTING CONDITION WAIVED <input type="checkbox"/> Yes <input type="checkbox"/> No PIBT ACCOUNT NO.
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.		

SECTION 2 EMPLOYEE INFORMATION

Last Name	First Name	M.I.	<input type="checkbox"/> Single <input type="checkbox"/> Married Date of Marriage _____ <input type="checkbox"/> Domestic Partner Registration Date _____
Social Security Number	Full Time Hire Date	Employment Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Job Title
Residence Mailing Address (Number, Street, Apartment)		City	State Zip
Home Telephone () ()	Mobile Phone Number () ()	<input type="checkbox"/> 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 <i>Last First M.I.</i>	Birthdate <i>MM/DD/YYYY</i>	Sex	Choose a Dental Office name and Facility # for each person
<i>Employee</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>	<i>Dental Office Name</i>
SS # — —	<i>Relationship</i> Self		<i>Facility #</i>
<i>Spouse</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>	<i>Dental Office Name</i>
SS # — —	<i>Relationship</i> Spouse		<i>Facility #</i>
<i>First dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>	<i>Dental Office Name</i>
SS # — —	<i>Relationship</i>		<i>Facility #</i>
<i>Second dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>	<i>Dental Office Name</i>
SS # — —	<i>Relationship</i>		<i>Facility #</i>
<i>Third dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>	<i>Dental Office Name</i>
SS # — —	<i>Relationship</i>		<i>Facility #</i>
<i>Fourth dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>	<i>Dental Office Name</i>
SS # — —	<i>Relationship</i>		<i>Facility #</i>

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