

Group Name Regis University			Group Number AL45	Effective Date	
<input type="checkbox"/> I apply for the following coverage for myself and dependents, as listed. <input type="checkbox"/> <u>Managed Care Plan</u> <input type="checkbox"/> Pinnacle			Facility ID #		
Employee First Name	MI	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	
Employee Street Address	City	State	Zip	Employee Social Security Number - -	
Home Phone ()	Work Phone ()	Division/Department/ Class		Date of Hire / /	
Dependents to be Included for coverage:			Sex	Date of Birth	Facility ID#
First Name	MI	Last Name	Relationship	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Check any boxes that apply and follow instructions <input type="checkbox"/> Are you covering more than three children? Please continue listing on additional Enrollment Forms. <input type="checkbox"/> Is the address of any child different than the member's? Show that child's name & address on the back of this form. <input type="checkbox"/> Are you requesting coverage for a dependent child other than a son or daughter? Forward legal custody paper. <input type="checkbox"/> Are you requesting coverage for dependent child over age 19 that is NOT a full time student? Furnish proof of incapacity within 31 days of the Effective Date.					
<input type="checkbox"/> I elect not to have coverage for my dependents or myself and I hereby waive coverage under the above mentioned plans.					
Signature: _____ Date: _____					
To the best of my knowledge and belief, each of the statements and answers supplied in this form are complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any coverage. Please read the following and sign below.					
The Managed Care Plan is underwritten by United Dental Care of Colorado, Inc.					
I hereby apply for membership in this dental Plan for myself and for any eligible dependents listed above. I authorize the [Group] named above to make deductions, if any, required as my contribution. I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the Plan and the terms and conditions of the Group Dental Service Agreement. I authorize any licensed dentist, physician, hospital or other health care provider to furnish the Plan with any required dental or medical information, as permitted by law about myself and any eligible dependents listed. I represent the information provided is true and correct to the best of my knowledge. I further understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I will promptly advise the Plan and my [Group] of any changes in this information.					
Signature: _____ Date: _____					