

## APPLICATION FOR ENROLLMENT OR CHANGE INSTRUCTIONS

To elect dental coverage, please fill out the attached form and return it to your Group Official.

### APPLICANT INSTRUCTIONS

Complete the following information:

**Box #1A - Dental Plan Option**

- Check off Dental Option

**Box #4 - Coverage Requested**

- Check off type of contract

**Box #6 A. - Eligible Persons to be Enrolled**

- Print last name, first name, middle initial, date of birth, sex, social security number for yourself and each dependent. \*If dependent is over contract age, check off reason: student or handicapped.

**B. Marital Status of Applicant**

- Check off appropriate box

**Box #7 - Applicant's Address and Phone Number**

- Print complete address and phone number

**Box #8 A - E - Other Group Dental Insurance**

- Print other group dental insurance information if you or any member of your immediate family have other dental insurance.

**Box #9 - For Presently Enrolled Customers Changing Their Coverage**

- Enter date of event: Month/Day/Year
- Enter identification number

**9A - Adding Dependent(s)**

**9B - Deleting Dependent(s)**

**9C - Continuing Coverage under COBRA**

- Complete data where applicable

**Box #10 - Signature**

- Please sign and date the application, return it to your Group Official to complete Sections 2, 3 and 5.

### GROUP OFFICIAL INSTRUCTIONS

Complete the following information:

**Box #1B - Insurer**

- Check off name of Insurer providing benefits.

**Box #2A - Group Name**

- Print your company's name

**2B - Group Number/Sub Group Number**

- Enter 7-digit group number

**2C - Proposed Effective Date**

- Enter applicant's proposed effective date of coverage

**2D - Remitting Agent's Signature and Date**

- Please sign and date the application

**Box #3 - Reason for Application**

- Check off the appropriate box

**Box #5 - Employment Information**

**5A - Date of Hire**

- Enter month/day/year

**5B - Date of Rehire**

- Enter month/day/year

**5C - Is employee actively at work?**

- Enter appropriate information

**NOTE:** To avoid processing delay, please review the entire application for completeness.

# NEW YORK APPLICATION FOR ENROLLMENT OR CHANGE

Horizon Healthcare Dental Programs  
P.O. Box 1938  
Newark, NJ 07101-1938  
1-888-667-4547

<b>1A DENTAL PLAN OPTION</b> (Check one Box only)	<b>1B INSURER</b>  <b>Horizon Healthcare Insurance Company of New York</b>	<b>2 GROUP INFORMATION</b> (Section 1 to be completed by employer.)	
<input type="checkbox"/> Horizon Dental Option <input type="checkbox"/> Horizon Dental PPO <input type="checkbox"/> Horizon Dental PPO Access		A. Group Name	B. Group No. / Subgroup No.
		C. Proposed Effective Date	D. Remitting Agent's Signature and Date
<b>3 REASON FOR APPLICATION</b>  Please check the appropriate box(es). <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Other _____		<b>4 COVERAGE REQUESTED</b>  Please check the appropriate box	
		<input type="checkbox"/> Adding/Deleting Dependents <input type="checkbox"/> Newly Eligible	
		Type of Contract	Single      Husband and Wife      Family      Parent and Child(ren)
<b>5 EMPLOYMENT INFORMATION</b> A. Date of Hire:      Mo.      Day      Yr.      B. Date of Rehire:      Mo.      Day      Yr.			
C. Is the employee actively at work?      If yes, indicate the number of hours worked per week _____ <input type="checkbox"/> yes <input type="checkbox"/> no      If no, check the appropriate box: <input type="checkbox"/> Pensioner <input type="checkbox"/> Disabled <input type="checkbox"/> Other (specify) _____			
<b>6 ELIGIBLE PERSONS TO BE ENROLLED</b> A. Complete this box for yourself and all dependents enrolling. Attach another application if you have more than four children. (Note: Dependent children are covered under a parent's contract only until they reach contract termination age as specified in the group contract.)			
LAST NAME	FIRST	MI	DATE OF BIRTH
			MO    DAY    YR
			SEX
			M/F
			FULL TIME STUDENT OVER CONTRACT AGE
			HANDICAP OVER CONTRACT AGE
			SOCIAL SECURITY NUMBER
Applicant			
Spouse			
Child			*      *
Child			*      *
Child			*      *
Child			*      *
Legal Ward			
* Verification is required for dependents over contract age for full time students and/or handicap.			
B. MARITAL STATUS OF APPLICANT <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)			
<b>7 APPLICANT'S ADDRESS AND PHONE NUMBER</b> Street _____ Area Code _____ City _____ State _____ Zip Code _____			
<b>8 OTHER GROUP DENTAL INSURANCE</b> (Please complete this if you or any member of your immediate family has other dental insurance.) A. Name of Policy Holder (Last, First) _____ B. Policy or Identification Number _____ C. Name of other Insurance Company _____ D. Address of other Insurance Company _____ E. Name and Location (City, State) of Spouse's Employer _____			
<b>9 FOR PRESENTLY ENROLLED CUSTOMERS CHANGING THEIR COVERAGE</b> (Check reason(s) for change and indicate the date of the event and ID number.) DATE OF EVENT      MO    DAY    YR      IDENTIFICATION NO. _____ _____      _____      _____      COPY FROM YOUR ID CARD _____			
A. ADDING DEPENDENT(S) (Be sure to complete section 6A.) <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Ward <input type="checkbox"/> Spouse's Coverage Terminated <input type="checkbox"/> Child <input type="checkbox"/> Adoption <input type="checkbox"/> Previously Refused/Waived Coverage <input type="checkbox"/> Other (specify) _____			
B. DELETING DEPENDENT(S) <input type="checkbox"/> Divorced/Separation <input type="checkbox"/> Coverage Elsewhere <input type="checkbox"/> Child Reached Termination Age or Married <input type="checkbox"/> Death <input type="checkbox"/> Entered Military <input type="checkbox"/> Other (specify) _____ Names of Dependents Being Deleted: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) _____			
C. CONTINUING COVERAGE UNDER COBRA <input type="checkbox"/> Spouse of Deceased Employee <input type="checkbox"/> Divorced <input type="checkbox"/> Reduction in hours/no longer meets Group's eligibility requirements <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Employment Terminated <input type="checkbox"/> Disabled <input type="checkbox"/> Dependent Child no longer eligible under terms of employer's health plan			
<b>10 SIGNATURE</b> I hereby apply to the company identified in Section 1B ("Horizon Healthcare") on behalf of myself and any eligible dependents listed. I understand and agree that any coverage provided pursuant to this application will be at the level of benefits available through arrangements between Horizon Healthcare and my group. I hereby accept responsibility for payment of any portion of the premium, if applicable, which I have agreed to pay through the group. I further acknowledge that coverage shall become effective only if approved by Horizon Healthcare and such services which are rendered on or after the effective date of coverage. I authorize Horizon Healthcare to request information from providers to assist in claims processing and to accept claims submitted electronically by third parties. I certify to the best of my knowledge and belief the information on this application is complete and true. I understand that any claim by me or one of my eligible dependents may be denied and my coverage cancelled without prior written notice if I have included false information. I also understand that such a termination will be retroactive to the effective date of our coverage.  Signature of Applicant _____ Date _____			<b>FOR PLAN USE ONLY</b> INPUT DATE AND INITIAL _____  VERIFY DATE AND INITIAL _____
<b>FRAUD WARNING:</b> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.			