FORTIS℠

GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name	Group Number	Effective Date
Pinnacle Plan	DU67	

❑ **I apply for the following coverage for myself and dependents, as listed.**

Managed Care Plan

❑ Insert DHMO Plan

Employee First Name	MI	Last Name	❑ M ❑ F	Date of Birth	Facility ID #
				/ /	

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:

First Name	MI	Last Name (if different)	Relationship	Sex	Date of Birth	Facility ID#
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	

Check any boxes that apply and follow instructions

- ❑ Are you covering more than three children? **Please continue listing on additional Enrollment Forms**.
- ❑ Is the address of any child different than the member's? **Show that child's name & address on the back of this form.**
- ❑ Are you requesting coverage for a dependent child other than a son or daughter? **Forward legal custody paper.**
- ❑ 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.**

❑ **I elect not to have coverage for myself or my dependents 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 is 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. and administered by Fortis Benefits Insurance Company

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:** _____