Dental Enrollment/Change Form

WESTERN HEALTH ADVANTAGE ADDENDUM

PREMIER ACCESS
Dental and Vision

This addendum must accompany a WHA Group Health Plan Enrollment/Change Form. All dependents enrolled under the medical plan will be enrolled under the dental plan.

Locate a provider: DMHO: 866.650.3660 PPO: 888.715.0760 premierlife.com

MEMBER INFORMATION Dental Coverage ☐ DHMO ☐ PPO

Employer _____ WHA Group # _____ Effective Date _____

Employee Last Name _____ First Name _____ MI _____

OTHER DENTAL COVERAGE Do you or your dependents have other dental coverage? ☐ Yes ☐ No (If yes, complete the information below.)

Name of Insured _____ Social Security Number _____

Insured's Employer _____ Insurance Carrier _____

Employer's Street Address _____

City, State, Zip _____ Phone _____

Are your dependent children enrolled under your spouse's or registered domestic partner dental plan? ☐ Yes ☐ No

FOR DHMO ONLY, PLEASE COMPLETE THIS SECTION: Please select a Primary Care Dentist (PCD) from the provider directory for yourself and each of your family members. Fill in the Provider ID# and Office ID# in the appropriate areas. If a selection is not made, a PCD will be assigned for you.

Relationship to Subscriber	Last Name	First Name	DMHO PCD Office ID#	DHMO PCP ID#
Self				
Spouse / Partner				
Child				
Child				

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE. THEREFORE, PREMIER ACCESS INSURANCE COMPANY WILL NOT REQUIRE THAT AN HIV TEST BE REQUIRED AS A CONDITION OF OBTAINING COVERAGE. IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFETY CODE SECTION 120980, PREMIER ACCESS INSURANCE COMPANY COMPLIES IN ALL RESPECTS WITH THE PROHIBITION AGAINST THE UNAUTHORIZED DISCLOSURES OF AN HIV TEST.

I, on my behalf and on behalf of my dependent(s) on this enrollment form, hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance, or agree that the contributions be added to my dues; (3) state that I became a full-time employee on the date stated on the reverse, and do currently work the number of hours per week stated on the reverse, (4) agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Premier* Certificate of Insurance, (5) agree that if I or my dependents receive dental services after my coverage is terminated or lapses, that I am responsible to reimburse Premier for any unrecovered payments made by Premier for such services, and (6) understand that verification of eligibility by Premier does not guarantee payment of claims and that retroactive eligibility changes supercede verifications of eligibility.

DENTAL RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Form, hereby authorize Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. If you request, Premier will provide a copy to you of any information it discloses to third parties regarding your dental information. This Dental Release authorization shall remain in effect thirty months from the date the application is signed. This Dental Release authorization solely provides authorization of Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. The dental information is being collected by Premier solely for the specific purpose of premium underwriting.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Form, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this form. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment form. I have read and agree to the notice on this form.

MANDATORY BINDING ARBITRATION: Premier Access Insurance Company uses binding arbitration to settle disputes, including to settle claims of dental malpractice. The insured understands and agrees that if a dispute arises in connection with this policy, the parties waive the right to a jury trial and must settle the dispute through binding arbitration. The Premier Certificate of Insurance contains a provision that further addresses this issue Premier Access Insurance Company does not use binding arbitration in connection with any dispute that an insured's life insurance coverage.

Employee signature: _____ Date: _____

Dental services offered herein are underwritten and administered by either, Premier Access Insurance Co (PAIC), a life/disability insurer licensed under the insurance laws of California or Access Dental Plan, Inc. (ADP), a specialized health care service plan licensed in the State of California under the Knox-Keene Health Care Service Plan Act of 1975.