UNITED CONCORDIA

America's Premier Dental Insurer

ENROLLMENT/CHANGE FORM

For *New Enrollment,* please complete all sections of this form. If you are enrolling for employee-only coverage, you do not need to fill in the *Dependent Information* section. **For** enrollment *Change,* please complete the *Type of Activity* and only the applicable changes along with the employee name and PFT Health & Welfare ID#.

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

☐ Concordia Flex - **PPO**

Return Address:
United Concordia Companies
Direct Pay
PO Box 69423
Harrisburg, PA 17106-9423

2. TYPE OF ACTIVITY

☐ **New Enrollment**

☐ **Change** ***(Please Specify}***

- ☐ Change Address
- ☐ Only Change Name
- ☐ Add Dependent(s)

Cancel Coverage for:

- ☐ Enrollee
- ☐ Spouse
- ☐ Dependents

☐ ***Death Certificate attached (If applicable}***

- ☐ **Continue Coverage for:**
  - ☐ Spouse of a deceased member
  - ☐ Child of a deceased member

3. GROUP INFORMATION

Group Name: **PFT Health & Welfare Fund**

Group Number: **099209**

Effective Date

__ / __ / ____

SECTION B: EMPLOYEE INFORMATION

Employee Name: (Last, First, Middle Initial)

PFT Health & Welfare ID#: (This# can be found on your current Capital Rx Card)

Date of Birth: __ / __ / ____

Home Address: City: State: Zip Code:

SECTION C: DEPENDENT INFORMATION

Social Security Number	Relationship	Last Name	First Name	Sex	Date of Birth
	Spouse				__ / __ / ____
	Dependent A				__ / __ / ____
	Dependent B				__ / __ / ____
	Dependent C				__ / __ / ____

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any Insurance company or other person, files an application for Insurance 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.

Employee Signature

Phone

Date __ / __ / ____