Intermountain
LiVe Well
Retirement Program

DENTAL INSURANCE APPLICATION

FOR SELECTHEALTH MEMBERSHIP

(Instructions on reverse side)

5245 South College Drive
Murray, UT 84123
801.442.3322, 800.528.7845

SUBSCRIBER NAME (LAST, FIRST, INITIAL)		
STREET		
CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	

FACILITY EMPLOYED		RETIREMENT DATE
SEX: ☐ FEMALE ☐ MALE	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	PARTICIPANT STATUS: ☐ RETIREE ☐ SURVIVING SPOUSE
SOCIAL SECURITY NO.:		

☐ **Retiree only** ☐ **Retiree and one dependent**

☐ **Family (retiree and two or more dependents)**

Choose one of the following:

☐ Utah Plan ☐ Out of Utah Plan

RELATIONSHIP TO RETIREE	NAMES OF MEMBERS TO BE COVERED (LAST, FIRST, INITIAL)	SOCIAL SECURITY NO.	SEX	BIRTHDAY MONTH / DAY / YEAR	AGE	NAME OF OTHER DENTAL INSURANCE CARRIER & POLICY NO.
SELF				/ /		☐ YES ☐ NO
SPOUSE				/ /		☐ YES ☐ NO
CHILDREN: ☐ ADOPT ☐ NATURAL ☐ OTHER				/ /		☐ YES ☐ NO
CHILDREN: ☐ ADOPT ☐ NATURAL ☐ OTHER				/ /		☐ YES ☐ NO

SIGNATURE OF SUBSCRIBER MUST BE COMPLETED BELOW TO VALIDATE APPLICATION. On the reverse side of this application, terms and conditions are listed which are an integral part of your application for benefits. Please read those provisions carefully. By signing, you acknowledge that you have read and understand the provisions of this plan.

Subscriber signature:_____**Date**_____

WAIVER OF COVERAGE ☐ I wish to waive or discontinue my dental insurance benefits. I choose not to participate in these dental insurance benefits for myself, my dependent(s) or my heirs, and hereby waive such coverage. I understand that I cannot enroll in dental until the next calendar year.

Subscriber signature:_____ Date_____

EMPLOYER USE

Coverage code:_____Effective date/retiree coverage_____ Intermountain authorization_____Date_____

Pension Path Input ☐ SelectHealth Notified ☐ Points:_____ Code:_____ Premium: _____

Instructions

- **General information**
  Please print your answers in either black or blue ink in all **unshaded** blanks. Shaded areas are for the use of SelectHealth and Intermountain Healthcare. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." Be sure to sign and date the form.

- **Member information**
  Please check the dental insurance program you have selected which is offered by your employer. Include your current address to ensure all pertinent mailing information will reach you. Your Social Security number is critical as all claims for you and your dependents are processed using your Social Security number.

- **Enrolled members**
  Including yourself, please list the sex, name, birthdate (month, day and year) and Social Security number of every eligible dependent to be covered under the requested insurance program. Please list surnames of dependents which differ from yours. For every dependent covered by another group plan, complete the appropriate dental carrier name(s). Make sure complete information is given for every dependent covered by other plans for coordination of benefits. Incomplete information may result in delayed claims processing. If you decline enrollment in this plan for yourself and/or any of your dependents (including your spouse) because of other dental insurance coverage, you may in the future be able to enroll the omitted individual(s) in this plan during the next calendar year after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application).

Terms and conditions

I authorize any source to release SelectHealth (hereinafter referred to as "the Plan") any dental, employment and/or insurance information requested on any enrolled member. I authorize payroll deduction of premiums as required. I agree to abide by the Plan's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I authorize my employer to act as my agent in all matters of administration of the group program and acknowledge that my employer is in no way acting as agent for the Plan. I understand there may not be participating dentists available in all specialty fields. Any matter in dispute between you and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of, the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction. I further certify that all information completed on this form is true and correct and acknowledge my coverage is subject to cancellation if any completed information is found to be false or incorrect.