UnitedHealthcare
Oxford

Dental Enrollment Form

Oxford Health Plans, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • 1-800-444-6222 • www.oxfordhealth.com

Plan Type: ❑ Premium ❑ Enhanced

To Be Completed By Employer (Please Print)

GROUP NAME	GROUP ID NUMBER	EMPLOYEE'S EFFECTIVE DATE OF COVERAGE
		/ /

EMPLOYER SIGNATURE
X

To Be Completed By EMPLOYEE (Please Print)

LAST NAME	FIRST NAME & MI		
STREET ADDRESS	APT. NO.	HOME PHONE	BUSINESS PHONE
CITY / STATE / ZIP	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE	DATE OF BIRTH MO. DAY YEAR
PRIMARY CARE DENTIST NAME*	PROVIDER CODE		

Dependent Information (Please Print)

SPOUSE'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR

ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR

ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR

ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR

* You must select a General Practice (GP) Dentist from Oxford's Roster of Participating Dentists for each family member.

Do you or your spouse have any other Group Dental Coverage? ❑ Yes ❑ No If yes, please give:

Name of Group Administrator/Plan ______________________________ Policy # ______________

I understand that my enrollment and benefits are in accordance with those described in the Oxford's Dental Rider. I agree to choose a participating Oxford General Practice Dentist for my primary dental care and to seek any necessary specialty care through Oxford participating Dental Specialists. I authorize any provider or insurer to furnish Oxford with any records concerning me or any member of my family for whom information is required. A photographic copy of this authorization shall be as valid as the original. I agree to submit any disputes with Oxford in accordance with the Oxford Health Plans Contract. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that I and any of my dependents have no other dental insurance other than that listed above. I certify that all the above information is correct.

X
EMPLOYEE SIGNATURE DATE