Enrollment/Change of Status Form

IMPORTANT: See other side for instructions.
Please print neatly and complete all sections.

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax:(877) 573-6177

1. Purpose of Form

Check One:
- ☐ Open Enrollment
- ☐ New Hire
- ☐ Re-Hire
- ☐ Change of Status

Important: *For Change of Status, this form will supersede all previous enrollment forms; please indicate all coverage you wish to begin or continue.*

For Change of Status, Check One:
- ☐ Name Change
- ☐ Provider Change
- ☐ Address Change
- ☐ Telephone Change
- ☐ Plan Change
- ☐ Dependent Change (Add or Remove)
- ☐ Enrollee (+Dependent) Removal

For Dependent Change,
Group Administrator must submit form to The Lincoln National Life Insurance Company within 31 days of Qualifying Event:

__/__/__

Check One:
- ☐ Marriage
- ☐ Newborn
- ☐ Divorce
- ☐ Other
- ☐ Legal Guardianship
- ☐ Loss of Coverage
- ☐ Adoption/Placement

Employer Use Only

Company Name _____

Group Number _____ Enrollee's Effective Date __/__/__

Plan Name (Dental) _____/_____

Employer Verification
Signature _____

Email _____

2. Enrollee *Please Note: The Lincoln National Life Insurance Company is referred to as "*Lincoln DentalConnect*SM DHMO"

Last Name _____ Date of Hire __/__/__

First Name _____ MI

Date of Birth __/__/__ Sex ☐ M ☐ F Social Security Number ___-___-____

Mailing Address _____

Apt # (or secondary address information) _____

City _____ State Zip _____

Home Phone # (___)___-____ Work Phone # (___)___-____

Spouse's Insurance Carrier (if applicable) _____ Effective Date of Spouse's Insurance __/__/__

Have you had any dental coverage within the last 60 days? ☐ Yes ☐ No

Provider Group Number _____ Dentist's Name/City _____

Existing Patient? ☐ Yes ☐ No

3. Selected Coverage

Select only plans offered by your employer.
Important: *For Change of Status, this form will supersede all previous enrollment forms; please indicate all coverage you wish to begin, continue or remove.*

Dental Plan Options:

☐ LDCCAC1	☐ LDCCAC2	☐ LDCCAC3	☐ LDCCAC4
☐ LDCCAV1	☐ LDCCAV2	☐ LDCCAV3	☐ LDCCAV4
☐ LDCCAC1c	☐ LDCCAC2c	☐ LDCCAC3c	☐ LDCCAC4c
☐ LDCCAV1c	☐ LDCCAV2c	☐ LDCCAV3c	☐ LDCCAV4c

☐ Remove

Individual(s) to be covered:
- ☐ Self
- ☐ Self + Spouse
- ☐ Self + Child(ren)
- ☐ Self + Family

For a list of DHMO dental Provider Groups in your area, visit **http://ldc.lfg.com** or check with your group administrator.

4. Dependents ☐ For Additional Dependents, check here and attach additional sheet.

1
Last Name _____ First Name _____ MI
☐ Add ☐ Remove
Relationship:
☐ Spouse
☐ Domestic Partner
☐ Daughter
☐ Son
Date of Birth __/__/__ Sex ☐ M ☐ F Social Security Number ___-___-____
Provider Group Number _____ Dentist's Name/City _____
Existing Patient? ■ Yes ☐ No

2
Last Name _____ First Name _____ MI
☐ Add ☐ Remove
Relationship:
☐ Spouse
☐ Domestic Partner
☐ Daughter
☐ Son
Date of Birth __/__/__ Sex ☐ M ☐ F Social Security Number ___-___-____
Provider Group Number _____ Dentist's Name/City _____
Existing Patient? ☐ Yes ☐ No

3
Last Name _____ First Name _____ MI
☐ Add ☐ Remove
Relationship:
☐ Spouse
☐ Domestic Partner
☐ Daughter
☐ Son
Date of Birth __/__/__ Sex ☐ M ☐ F Social Security Number ___-___-____
Provider Group Number _____ Dentist's Name/City _____
Existing Patient? ☐ Yes ☐ No

Return completed form to your Group Administrator.

Lincoln DentalConnect* **DHMO Plans are underwritten by Dental Benefit Providers of California, Inc. ("DBP-CA").

I understand and agree to the terms and conditions on the reverse side of this sheet.

X **Enrollee Signature** _____ Date _____

Instructions for completing this Form

1) **Check all appropriate boxes and print all information clearly:** It is important that you check all appropriate boxes. Be sure to indicate whether you are enrolling for the first time or changing your information.
2) **Enrollee:** This section must always be filled out completely. **For a list of Provider Groups in your area, visit http://ldc.lfg.com or check with your Group Administrator.**
3) **Selected Coverage:** Please indicate the plan(s) in which you are enrolling or continuing. Not all plans are available to all groups or in all states. Your Group Administrator will know which plans are available to you. Select only plans offered by your employer.
4) **Dependents:** All dependents you wish to be covered should be listed in this section.
5) **Refusal of Employee and/or Dependent Coverage:** If you do NOT wish coverage for either yourself or dependents, please complete and sign the **Refusal of Employee and/or Dependent Coverage Insurance** (available from your Group Administrator).
6) **Changing information:** If you are changing information previously submitted, please enter the changed information in the appropriate section. Be sure to mark the reason you are changing information in the box labeled "**For Change of Status**" at the top of the form.
7) **Terms and Conditions:** Read the **Terms and Conditions** below and sign in the box on the front at the "X." **This form must be signed for coverage to be effective.**
8) **Return completed form to your Group Administrator. This form cannot be processed if information is incomplete.**

Enrollment/Change of Status - Checklist

This form cannot be processed if information is incomplete and will be returned. Please use this checklist to include all necessary information to process your enrollment form.

Enrollee:

- ☐ Signature
- ☐ Social security number
- ☐ Address
- ☐ Date of birth
- ☐ Provider Group selection

Group Administrator:

- ☐ Company name
- ☐ Group number
- ☐ Enrollee's effective date of coverage
- ☐ Plan name
- ☐ Employer verification signature

Terms and Conditions

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

I agree and understand that any and all disputes, including claims of dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims under ERISA, between myself and The Lincoln National Life Insurance Company and/or DBP-CA, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort, to court process, except as state law provides for judicial review of arbitration proceedings. Both parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration

Group Administrator, please mail completed form to:

The Lincoln National Life Insurance Company
P.O. Box 2616
Omaha, NE 68103-2616