PAA Insurance Programs
1-800-222-8712

Application To Enroll Or Change Enrollment
Dental and Vision Only

1. Subscriber Information:

Subscriber Name (Last, First, MI):

_____

Street Address:

_____ New Address ? ☐ Yes ☐ No

City: _____ State: _____ Zip: _____ County: _____

Social Security Number: ___-___-____ Birth Date: ___/___/___

☐ Male ☐ Female ☐ Single ☐ Married

☐ Active ☐ Retired ☐ COBRA

2. Employer Information: Group Number: D _____ V

Employer Name _____ Dealer # _____

Employer Address _____

_____

Effective Date ___/___/___ Hire Date ___/___/___

3. Reason For Submission:

☐ **New:**

☐ New Hire

☐ Open Enrollment

☐ Life Status Event —
Indicate event date: _____

☐ **Change:**

☐ Add Dependent /Spouse — If adding spouse, indicate date of marriage: _____

☐ Delete Dependent/Spouse —
indicate event date _____ and reason:
☐ Overage Dependent ☐ Divorce
☐ Other Coverage ☐ Death

4. Enter "A' to Add or "R" to Remove		5. Enrollment/Change Information — List All Family Members To Be Covered					
United Concordia Dental	Davis Vision	Last Name	First Name	MI	Birth Date	Social Security Number	♿
		SELF			/ /		
		SPOUSE			/ /		
		SON DAU			/ /		
		SON DAU			/ /		
		SON DAU			/ /		

6. Change The Following Information: ☐ **For Subscriber** ☐ **For Dependent**

Name	From	To
Birth Date	From	To
Social Security Number	From	To

7. Authorization:

Signature of Employee **Date**

Signature of Employer **Date**