Pediatric Dental Form

FOR GROUP COVERAGE

ACCESS DENTAL

Access Dental's Smile for Kids DHMO (EHB) benefits are included in WHA's Gateway and Capital group plans. Benefits are available for members up to the age 19.

Employer _____ WHA Group ID #_____

Employee Last Name _____ First Name _____ MI_____

SELECT A PRIMARY CARE DENTIST (PCD) — COMPLETE FOR ALL MEMBERS AGE 19 AND UNDER

Provide full name for each member covered on your plan age 19 and under, including yourself, if applicable. Visit **premierlife.com** or call **877.702.8800** to select a PCD for each member; indicate PCD's Office and Provider ID Numbers in the appropriate areas. If a selection is not made, a PCD will be assigned for you.

LAST NAME	FIRST NAME	DMHO PCD OFFICE ID#	DHMO PCD ID#

OTHER DENTAL COVERAGE If anyone listed above has other dental coverage, complete the information below.

Name of Insured _____ Social Security Number _____

Dental Insurance Carrier _____

Insured's Employer _____ Employer's Phone_____

Employer's Address _____

Are your dependent children, if any, enrolled under your spouse's or registered domestic partner's dental plan? ❑ Yes ❑ No

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE. THEREFORE, ACCESS DENTAL WILL NOT REQUIRE THAT AN HIV TEST BE REQUIRED AS A CONDITION OF OBTAINING COVERAGE. IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFETY CODE SECTION 120980, ACCESS DENTAL COMPLIES IN ALL RESPECTS WITH THE PROHIBITION AGAINST THE UNAUTHORIZED DISCLOSURES OF AN HIV TEST.

DENTAL RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Form, hereby authorize Access to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Access. If you request, Access will provide a copy to you of any information it discloses to third parties regarding your dental information. This Dental Release authorization shall remain in effect thirty months from the date the application is signed. This Dental Release authorization solely provides authorization of Access to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Access. The dental information is being collected by Access solely for the specific purpose of premium underwriting.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this form. I understand that Access Dental Plan, Inc. reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment form. I have read and agree to the notice on this form.

Employee signature: _____ Date: _____