

## Benefit Summary

### XAVIER UNIVERSITY Buy-Up Plan

**Product:** DHMO

**Network:** Dental Care Plus

**Benefit Year:** The 12 month period beginning January 1st and ending December 31st (calendar year)

**Annual Maximum Benefit:** \$1000 per Member

**Orthodontic Lifetime Maximum Benefit:** \$500 per Eligible Member  
Limited to eligible dependent children under age 19

**Deductible:** \$50 per Member, per Benefit Year  
\$150 per Family, per Benefit Year

The deductible applies to Basic and Major Benefits only

Covered Dental Services	Deductible Applied	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None
Basic Benefits	Yes	60%	40%
Major Benefits	Yes	40%	60%
Orthodontic Benefits	No	50% Limited to eligible dependent children under age 19	50%

**Endodontic Services are covered as Basic Benefits.**

**Periodontic Services are covered as Basic Benefits.**

**Sealants are covered as Basic Benefits.**

**Dependent children are eligible for coverage until age 26.**

**A complete description of benefits, limitations and exclusions are available in the Member Handbook. Members must receive services from a Dental Care Plus dentist.**

**Benefit Summary**

**XAVIER UNIVERSITY  
Core Plan**

**Product:** DHMO

**Network:** Dental Care Plus

**Benefit Year:** The 12 month period beginning January 1st and ending December 31st (calendar year)

**Annual Maximum Benefit:** \$750 per Member

**Orthodontic Lifetime Maximum Benefit:** \$0 per Eligible Member

**Deductible:** \$50 per Member, per Benefit Year  
\$150 per Family, per Benefit Year

The deductible applies to Basic Benefits only

Covered Dental Services	Deductible Applied	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None
Basic Benefits	Yes	50%	50%
Major Benefits	No	0%	100%

**Endodontic Services are covered as Basic Benefits.**

**Periodontic Services are covered as Basic Benefits.**

**Sealants are covered as Basic Benefits.**

**Dependent children are eligible for coverage until age 26.**

**A complete description of benefits, limitations and exclusions are available in the Member Handbook. Members must receive services from a Dental Care Plus dentist.**

# Your dental benefits.

*Your employer took a smart step by partnering with The Dental Care Plus Group (DCPG) for your dental benefits. We are proud to be your company's preferred dental insurance carrier and look forward to serving you.*

Having dental insurance just makes sense – both for your physical health and your budget. Better oral health can lead to better overall health as well as save you money on more involved, costly dental services or health problems.

## Who we are

Here at DCPG, we specialize in dental benefits and have for more than 30 years. That experience might just qualify us as the experts in dental. It's a role we're happy to fill. We've worked with your employer to present you with solid, affordable coverage and extensive access to dentists.

## Already enrolled?

Great! The contents of this packet contain the most up-to-date information about your plan. Follow the instructions provided by your employer for any required paperwork.

## Ready to enroll?

It's easy to get started. Enroll in a plan by completing the required paperwork and submitting it to your benefits administrator. On or around your effective date, you will receive your member ID cards in the mail. From there, it's really easy to get started using your benefits. And we want you to use your dental benefits because when you do, it shows in your smile.

## Get the dental care you need with:

- **No waiting periods on any services including preventive, basic or major.** Start seeing your dentist immediately on your effective date.
- **Two cleanings per benefit year.** We don't require you to wait six months between cleanings.
- **White fillings on all teeth.** Breathe a sigh of relief knowing you can have white (composite) fillings on all your teeth, even those teeth in the back of your mouth. Your plan won't require silver fillings on certain teeth.
- **Fourth quarter deductible carryover.** Say you need dental services and you pay your deductible in the last three months of your plan year. We'll go ahead and consider your deductible paid for the next plan year as well. This is just a fancy way of saying: we like to save you money.

## Customer service that's on point.

**Have a question about what your plan covers? Or maybe a claims question? Go ahead, give us a call.**

When you call during business hours, a person will answer the phone, not a recording. That means no long wait times or recorded voice menus. You can reach our customer service department Monday through Friday from 8:00 am until 4:30 pm EST at (800) 367-9466. Or send us a message anytime by visiting the "Contact Us" page on our website: [DentalCarePlus.com](http://DentalCarePlus.com).



# Member services

## Go online

Our member portal is a one-stop-shop to review benefit information, check the status of claims or order new ID cards. You can also access the Oral Health Center, use the dental cost estimator and sign up to receive our Member Checkup eLetter – all excellent ways to receive tips on improving your dental health.

Once you have enrolled in a plan, register for the member portal by visiting [DentalCarePlus.com](http://DentalCarePlus.com), selecting “Group Member” in the top right corner, then clicking on “Login” to get started.

## Find a dentist

With our online provider search, it's easy to find an in-network dentist or specialist. Simply visit [fad.dentalcareplus.com](http://fad.dentalcareplus.com) or click on the “Find a Dentist” tab at the top of DCPG's home page. Once there, choose your network (found on the benefit summary document in this packet, on your member ID card or by asking your benefits administrator), then decide if you want to search by ZIP code, county or the dentist's last name. If you find that your dentist isn't listed, fill out a nomination form (included in this packet or available on our website) so we may begin the process of inviting them to join our network.



## Hearing health is included

Your dental plan comes with a hearing program that can save you money on devices including name-brand hearing aids and batteries.

You can easily get on the path to better hearing by calling EPIC Hearing Health Care at (888) 899-1485 or visiting [EpicHearing.com](http://EpicHearing.com) to access this program.



**If you have questions, please contact your benefits administrator. If you'd like to learn more about The Dental Care Plus Group, visit [DentalCarePlus.com](http://DentalCarePlus.com).**



**Connect with us.**

**Make sure to follow us on social media!**

[linkedin.com/company/the-dental-care-plus-group](https://www.linkedin.com/company/the-dental-care-plus-group)

[@DC\\_Plus](https://twitter.com/DC_Plus)

[facebook.com/DentalCarePlus](https://www.facebook.com/DentalCarePlus)



## Wait, there's more.

**These tips will help you save time and money as you make the most of your benefits:**

- Find out what your plan covers and what it doesn't. DCPG's customer service department can help explain your benefits and plan details.
- Request that your dentist provide a pretreatment review to DCPG when he or she recommends services that exceed \$400. This will help you plan for your portion of the expense.
- Know your plan's annual maximum since you will be responsible for costs that exceed this amount.

## NOTICE OF PRIVACY PRACTICES

DENTAL CARE PLUS, INC.

P.O. Box 62262 • Cincinnati, OH 45262 513-554-1100

Effective date of this notice: September 23, 2013

If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### SUMMARY

In order to provide you with benefits, Dental Care Plus, Inc. will receive personal information about your dental health. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

### HOW WE MAY USE OR DISCLOSE YOUR DENTAL HEALTH INFORMATION.

We may use your dental health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information.

**1. Treatment.** We may use your dental health information to provide you with dental care and services. This means that our employees, staff, students, volunteers and others, whose work is under our direct control, may read your dental information to learn about your dental condition and use it to help you make decisions about your care. For instance, a dental plan consultant may use dental health information to determine a treatment plan.

**2. Payment.** We will use your dental health information, and disclose it to others, as necessary to make payment for the dental care services you receive. For instance, we may use your dental health information to pay your claim, we may send information to the dental care professional that provided you with the dental care services, or we may send information to another insurance company to coordinate your benefits. If you owe us money, we may give information about you to a collection company that we contract with to collect bills for us.

**3. Dental Care Operations.** We may use your dental health information for activities that are necessary to operate this organization. This includes using your information to plan what services we need to provide, expand, or reduce, and to evaluate quality and improve our operations.

**4. Business Associates.** We may disclose information to third parties or organizations that we contract with to perform services for us. We require these third parties and outside organizations to protect the privacy of your information.

**5. Legal Requirement to Disclose Information.** We are permitted to disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the dental care system. For instance, we may be required to disclose your dental health information if we are audited by the state insurance department. We may also disclose your information in the following circumstances:

- when we are required to do so by a court order or other judicial or administrative process.
- when the information relates to a victim of abuse, neglect or domestic violence for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity.
- to a federal agency investigating our compliance with federal privacy regulations.
- if you are a member of the armed forces, as authorized by military command authorities.
- to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation);
- for national security, intelligence, and protection of the president.
- if you are an inmate, to a correctional institution or to law enforcement officials to provide you with dental care, to protect the dental safety of you and others, and for the safety, administration, and maintenance of the correctional institution.
- to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance)
- if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual.

**6. Family and Friends Involved In Your Care.** With your approval, we may from time to time disclose your personal dental information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency situation and we determine that a limited disclosure may be in your best interest, we may share limited personal dental information with such individuals without your approval. We may also disclose limited personal dental information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**7. Information to Members.** We may use your dental health information to provide you with additional dental health related information. This may include mailing dental education materials to your address.

**8. Dental Benefits Information.** If your enrollment in the Dental Care Plus dental plan is sponsored by your employer, your dental health information may be disclosed to your employer, as necessary for the administration of your employer's dental benefit program for employees. Employers may receive this information only for purposes of administering their employee group dental plans, and must have special rules to prevent the misuse of your information for other purposes.

**9. Genetic Information.** We will not use or disclose any genetic information about you or your family members for underwriting or benefit eligibility determinations.

### YOUR RIGHTS

**1. Authorization.** We may use or disclose your dental health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your dental health information for any other reason without your authorization. For example, we will obtain your authorization before using or disclosing your dental health information for:

**Marketing Communications** unless the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment.

**Most Sales** of your dental health information unless for treatment or payment purposes or as required by law.

If you authorize us to use or disclose your dental health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your dental information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization.

**2. Request Restrictions.** You have the right to ask us to restrict how we use or disclose your dental health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

**3. Confidential Communication.** You have the right to request that we communicate with you by alternative means. This request must be in writing. If we can reasonably accommodate your request within the confines of our system, we will do so. If your request is because you believe the disclosure of information could endanger you, you must notify us of that fact and your request will be accommodated if it is reasonable.

**4. Inspect And Receive a Copy of Dental Health Information.** You have a right to inspect the dental health information about you that we have in our records, and to receive a copy of it. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice.

**5. Amend Dental Health Information.** You have the right to ask us to amend dental health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We are not required to make all requested amendments, but we will consider your request carefully. To request an amendment to your information, contact the person listed under "Whom to Contact" at the end of this notice.

**6. Accounting of Disclosures.** You have a right to receive an accounting of certain disclosures of your information to others. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. We cannot include disclosures made before April 14, 2003. To request an accounting, contact the person listed under "Whom to Contact" at the end of this notice.

**7. Notice of Breach.** In the unlikely event that there is a breach, or unauthorized release of your dental health information, you have the right to receive notice and information from us on steps you may take to protect yourself from harm.

**8. Paper Copy of this Privacy Notice.** You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

**9. Complaints.** You have a right to complain if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Secretary of the U. S. Department of Health and Human Services, at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. All complaints must be in writing. We will not take any action against you if you file a complaint.

### OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any dental health information which we already have, as well as to dental health information we receive in the future. We will mail the new notice to all subscribers within 60 days of the effective date.

### WHOM TO CONTACT

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current Notice of Privacy Practices.

Contact: Privacy Officer  
Dental Care Plus, Inc.  
P.O. Box 62262  
Cincinnati, OH 45262  
513-554-1100 or 800-367-9466

Copies of this notice are also available at the Dental Care Plus, Inc. office or on our Web site: [www.dentalcareplus.com](http://www.dentalcareplus.com). You may also request a copy by email. Contact the Privacy Officer or send an email to: [hipaa@dentalcareplus.com](mailto:hipaa@dentalcareplus.com).

# Nomination form.

To determine if your dentist is a participating provider with The Dental Care Plus Group (DCPG), search our online directory at: [fad.DentalCarePlus.com](http://fad.DentalCarePlus.com). If your dentist is not listed, simply fill out the nomination form below so that we may contact him/her and extend an invitation to begin the process to join our networks. You may also submit the nomination form through the Find a Dentist page (link above).

**Please provide the following:**

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Your Name

Today's Date

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Your Employer's Name (please do not abbreviate)

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Dentist Name

---

Street Address

---

City

State

ZIP code

---

County

Phone

May we use your name in our recruiting efforts with your dentist?  Yes  No

**Please return completed form with your enrollment application or:**

**By email:** [providerrelations@dentalcareplus.com](mailto:providerrelations@dentalcareplus.com)

**By fax:** (513) 618-3881, Attn: Provider Recruiting and Contracting

**By mail:** The Dental Care Plus Group, Attn: Provider Recruiting and Contracting, 100 Crowne Point Place, Cincinnati, OH 45241

*The completion of this form is a request for DCPG to begin the recruitment process with your dentist. This does not guarantee that your dentist will become a participating provider.*

**For more information, call (800) 367-9466 or visit [DentalCarePlus.com](http://DentalCarePlus.com).**

T H E P L U S I S S E R V I C E

## Welcome to Your Total Vision Services Discount Program

The Dental Care Plus Group is pleased to offer you access to a free vision discount program with your dental benefits plan. You and your eligible dependents will be enrolled in one of two programs offered by Total Vision Services (TVS): the TVS program or the Coast to Coast program. Both programs feature discounts with unlimited usage, no additional paperwork to file and no health restrictions. Your enrollment in the appropriate program is automatic and based on your home ZIP code.

### *Vision Schedule*

TVS contracts with ophthalmologists and optometrists in selected markets across the country to provide you with discounts on eyeglasses, contact lenses, eye exams and surgical procedures (including PRK & LASIK surgery) where available. If your ophthalmologist or optometrist doesn't contract with TVS, you can give their name, address and phone number to a TVS representative and they will be invited to start the process to join the program.

Your program comes with:

- Discounts on frames, lenses and specialty items such as tints, scratch-resistant coatings and ultraviolet protection.
- No limit on the number of times you and your family may use the membership during the year.
- Savings of 10-30 percent on medical eye exams and surgical procedures including refractive surgery (PRK & LASIK).

To locate a participating provider near you, simply call (800) 869-5400 or visit [TotalVisionServices.com](http://TotalVisionServices.com).

### **Elective Eye Surgeries**

In keeping with the tradition of utilizing both chain and independent providers, TVS contracts with national chains of laser surgery centers to provide discounts on refractive laser surgery. In addition, TVS contracts with independent ophthalmologists who provide discounts on refractive surgery. Payment must be made at the time of service to receive a discount. Call TVS at (513) 921-7500 or (800) 869-5400 for information regarding discounts. Usual and customary charges vary between physicians.

### **America's Eyewear (Replacement Contacts)**

Note: this is only available through the Coast to Coast program.

Members receive greater savings on contact lenses through the TVS mail-order program. Simply call (800) 800-EYES for price quotes and to place an order. Most orders are fulfilled within 7 to 14 days.

- Savings of 10-40 percent through mail-order service.\*
- Most types of contact lenses are available including disposables, torics, bifocals and gas permeable lenses.

*Some brands available through the mail-order program include:*

- **Disposable:** Acuvue, Durasoft, Encore, Freshlook, Biomedic, Soflens 66, Optima FW, Focus
- **Gas Permeable:** Boston, Fluoroperm, SGP, Transaire

### **How to use the Total Vision Services program**

Simply present your Dental Care Plus Group member ID Card at any of the participating provider locations to receive your program discount. If you decide to use your own eye doctor and not take advantage of the reduced examination fees under the TVS program, you may take your prescription to any of the participating provider locations and they will fill it for you at TVS program rates.

### **How to use the Coast to Coast program**

TVS will issue you a Coast to Coast ID Card which you must present prior to service to a participating provider. Tell the provider that you are a member with access to the Coast to Coast vision program. Should you decide to use your own eye doctor and not take advantage of savings on examination fees under the Coast to Coast program, take your prescription to any of the provider locations to receive the Coast to Coast discount on materials (frames and lenses). For the provider locations nearest you, contact the Coast to Coast vision program at (800) 800-EYES or search online at [TotalVisionServices.com](http://TotalVisionServices.com).

## Total Vision Services Out-of-Pocket Fee Schedule

### Eye Examinations

Optometrist Eye Examination (Dilation Included) . . . . .	25% off UCR
Ophthalmologist Eye Examination . . . . .	\$69 Flat Fee

### Standard Plastic Lenses (CR-39)

Single Vision . . . . .	\$39
Bifocals (FT-25, FT-28) . . . . .	\$60
Trifocals (FT-7/25, FT-7/28) . . . . .	\$70
Progressive Bifocals (Excluding Specialty Designs) . . . . .	\$112

### Strong Power Charge

Sphere and Cylinder Greater than + or – 4 Diopters . . . . .	Add \$5/Per Lens
Sphere and Cylinder Greater than + or – 8 Diopters . . . . .	Add \$15/Per Lens

### Lens Options

Standard Tint . . . . .	add \$15
Tint (Solid or Gradient) . . . . .	add \$15
Standard Scratch Coating . . . . .	add \$15
UV Treatment . . . . .	add \$15

Standard Anti-reflective Coating . . . . .	add \$40
Polycarbonate – Single Vision . . . . .	add \$30
Polycarbonate – Bifocal/Trifocal . . . . .	add \$35
Polycarbonate – Progressive . . . . .	add \$45
Hi Index 1.60 – Single Vision . . . . .	add \$35
Hi Index 1.60 – Bifocal/Trifocal . . . . .	add \$45
Hi Index 1.60 – Progressive . . . . .	add \$55

### Prescription Remake Policy (per pair)

Single Vision Lenses . . . . .	\$10
Bifocal Lenses . . . . .	\$15
Progressive Lenses . . . . .	\$20

### Frames

All Frames up to \$150 Retail . . . . .	40% off
All Frames over \$150 Retail . . . . .	30% off

**Any optical products not listed on the fee schedule above will be subject to a 25% discount off the regular retail price. Manufacturers rebates may be used in conjunction with the fee schedule pricing. Prices are subject to change.**

### Contact Lenses

Professional Services (i.e. fitting fees, follow-up visits, polishes, etc.) are 25% off regular retail prices. All contact lens fitting fees include a follow-up visit and solution.

*Note: Provider may require one year minimum order of disposable lenses.*

### Disposable Contact Lenses

Sphere, Aspheric, Toric, Multifocal and Cosmetic Includes: One Day Disposables, Two-Week Disposables and Silicon Hydrogel . . . . .	10% off Retail
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### Specialty Soft Lenses – Non-disposable

Toric, Bifocal, Piggyback, Softperm, Cosmetic, Therapeutic, Post-Operative . . . . .	20% off Retail
Rigid Gas Permeable Lenses Spherical, Front, Back and Bitoric, Bifocal, Kerataconus, Graft, Lenticular and etc. . . . .	20% off Retail

**All contact lenses not listed by type or brand name are 20% off regular retail, except for disposable lenses, which are 10% off regular price.**

**For more information, contact Total Vision Services  
at (800) 869-5400 or visit [TotalVisionServices.com](http://TotalVisionServices.com).**

**T H E P L U S I S S E R V I C E**



ALL SECTIONS MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED.

**ENROLLMENT FORM**

SOCIAL SECURITY NUMBER --- --		GROUP NUMBER	EMPLOYER AND LOCATION	
EMPLOYEE LAST NAME	FIRST NAME	MI	EMPLOYEE'S HOME PHONE	
			EMPLOYEE'S EMAIL ADDRESS	
HOME ADDRESS		APT#	GENDER	DATE OF BIRTH
CITY	STATE	ZIP CODE	COUNTY IN WHICH YOU RESIDE	
MARITAL STATUS: <input type="checkbox"/> SINGLE (01) <input type="checkbox"/> MARRIED (02)		EMPLOYMENT DATE	EFFECTIVE DATE	

APPLICATION FOR DENTAL COVERAGE (CHECK THOSE THAT APPLY)  EMPLOYEE  SPOUSE  CHILD(REN)

**COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE COVERED BY THE PLAN**

NAME – IF LAST NAME DIFFERENT FROM ABOVE INDICATE LAST NAME	RELATIONSHIP	GENDER	BIRTH DATE
	<b>SPOUSE</b>		

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? \_\_\_\_\_ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: \_\_\_\_\_

**REFUSAL/WAIVER – COMPLETE ONLY IF YOU ARE DECLINING COVERAGE FOR YOURSELF OR ANY DEPENDENT**

I DECLINE COVERAGE FOR:  MYSELF  MY SPOUSE  MY CHILDREN

REASON FOR REFUSAL: \_\_\_\_\_

On behalf of myself and any dependants listed above, I hereby apply for coverage under the Master Group Policy/Contract issued to my employer by Dental Care Plus, Inc. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Policy/Contract and any changes provided for therein. I understand that certain services may require copayment or deductible, payable by me (or my dependents) directly to the provider of such services. I authorize my employer to deduct the necessary contributions, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan, and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation.

I hereby waive the dentist-patient privilege and authorize any dentist or other provider of dental services to give Dental Care Plus, Inc., its agents and representatives any information concerning the claims for reimbursement for covered services of any person included under such coverage, including the undersigned, the undersigned's spouse and the undersigned's dependents.

To the best of my knowledge, the above information is complete, true, and correct. In the absence of fraud, however, all statements made by applicants or by an insured person shall be deemed representations and not warranties.

**PLEASE SIGN WHETHER YOU ARE ACCEPTING OR DECLINING COVERAGE**

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Fraud Notice - Ohio Residents Only:** Any person who, with intent to defraud or knowing that he 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.

**Fraud Notice – Kentucky Residents Only:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

**Fraud Notice – Indiana Residents Only:** Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

**Fraud Notice – Tennessee Residents Only:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

100 Crowne Point Place • Cincinnati, OH 45241  
 Phone (513) 554-1100 • 1-800-367-9466  
 Fax (513) 618-3882

- Name/Address change: fill in Section 1
- Add/Terminated dependents: fill in Section 2
- Terminate/Reactivate coverage: fill in Section 3

SOCIAL SECURITY NUMBER _____	EMPLOYEE LAST NAME	FIRST NAME	MI
EMPLOYER		GROUP NUMBER	

### SECTION 1

ADDRESS CHANGE	NEW ADDRESS	CITY	STATE	ZIP CODE
NAME CHANGE	THE REASON FOR THE CHANGE IS (CHECK ONE):			
	<input type="checkbox"/> MARRIAGE <input type="checkbox"/> CORRECTION <input type="checkbox"/> DIVORCE <input type="checkbox"/> COURT ORDER			
CHANGE NAME FROM:	TO:			

### SECTION 2

ADD DEPENDENT(S)

#### COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE ADDED TO THE PLAN

	NAME(S) OF DEPENDENT(S) TO BE ADDED:	SEX	BIRTH DATE	EFFECTIVE DATE	RELATIONSHIP	REASON
01						
02						
03						
04						

Will you or any dependent be covered under another dental insurance plan while a member of Dental Care Plus Insurance Company?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name and address of other insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

DELETE DEPENDENT(S)

#### COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE REMOVED FROM THE PLAN

	NAME(S) OF DEPENDENT(S) TO BE DELETED:	SEX	BIRTH DATE	EFFECTIVE DATE	REASON
01					
02					
03					
04					

### SECTION 3

#### TERMINATE COVERAGE

REASON:     TERMINATED EMPLOYMENT   
  NO LONGER ELIGIBLE   
  COBRA ELIGIBILITY ENDED   
  OPEN ENROLLMENT

DATE COVERAGE ENDS: \_\_\_\_\_

#### REACTIVATE COVERAGE

REASON:     TERMINATED IN ERROR   
  ELECTED COBRA   
  REHIRED   
  COURT ORDER

EFFECTIVE DATE: \_\_\_\_\_

#### OTHER

STATE CLEARLY THE REQUESTED CHANGE: \_\_\_\_\_

**X ADMINISTRATOR/EMPLOYEE SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Fraud Notice - Ohio Residents Only:** Any person who, with intent to defraud or knowing that he 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.  
**Fraud Notice - Kentucky Residents Only:** Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.