ChoiceBuilder®
721 South Parker, Suite 200, Orange, CA 92868
Phone: (866) 412-9279 • Fax (866) 412-9280
www.choicebuilder.com

Dental / Vision / Chiropractic / Life Enrollment Form

- Form must be Completed in Full, Signed and Dated for processing.
- If you are waiving coverage, you must complete, sign and date waiver on page 4 of this application.
- E-mail address: memberprocessing@choicebuilder.com

Please select one: ☐ New Hire Enrollment ☐ New Renewal Enrollment ☐ New COBRA Enrollment ☐ Qualifying/Triggering Event

If you are an existing member, and are changing dental plans or adding a plan, please use an Employee "Change Request Form". For Primary Dental Office changes only, please contact your dental plan directly.

A. PERSONAL INFORMATION

Company Name: WIRELESS WATCHDOGS

Company Phone # (XXX) XXX-XXXX:

Employee Job Title:

Full-Time Employment Date (MM/DD/YYYY):

Gender ☐ M ☐ F Status ☐ Married ☐ Single ☐ Domestic Partner

Group #: B 0 5 3 5 0

Employee Last Name:

Employee Social Security #:

Employee First Name:

M.I.:

Date of Birth (MM/DD/YYYY):

Phone # (XXX) XXX-XXXX:

E-mail Address:

Physical Address (Do not use P.O. Box):

Apt. #:

City:

State:

ZIP Code:

Mailing Address *(if different from above)*:

Apt. #:

City:

State:

ZIP Code:

B. ENROLLMENT INFORMATION

Complete this section ONLY if you are electing dental, vision and/or chiro for yourself and dependents.

	Employee	Spouse/Domestic Partner	Child	Child	Child
Enrolling For?	☐ Dental ☐ Vision ☐ Chiro	☐ Dental ☐ Vision	☐ Dental ☐ Vision	☐ Dental ☐ Vision	☐ Dental ☐ Vision
Last Name					
First Name					
Relationship to Employee		☐ Spouse ☐ Domestic Partner			
Social Security #		Social Security # required	Social Security # required	Social Security # required	Social Security # required
Gender		☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth		(MM/DD/YYYY)	(MM/DD/YYYY)	(MM/DD/YYYY)	(MM/DD/YYYY)
Disabled? (Complete only if over age 26)			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*If you are enrolling a disabled dependent you must complete a Disabled Dependent Form. (form can be found on the ChoiceBuilder® website)

COBRA APPLICANTS
Please check COBRA type:
☐ COBRA
☐ Cal-COBRA

Indicate Qualifying/Triggering Event
☐ Termination of employment ☐ Child no longer eligible ☐ Medicare entitlement
☐ Reduction of hours ☐ Divorce/legal separation ☐ Death of employee

Date of Qualifying/Triggering Event (MM/DD/YYYY):

PLEASE SIGN AND DATE APPLICABLE SECTIONS INSIDE FORM

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Print Employee Name _____ Group # B 05350

C. DENTAL BENEFIT

Select ONE plan *(see worksheet for plan availability)*

DeltaCare® USA DHMO
☐ Gold ☐ Silver ☐ Bronze

OR

PPO
☐ Platinum Plus ☐ Platinum ☐ Gold ☐ Silver

Select a Dental Office (DHMO ONLY) *(If the Dental Office selected is not available or one was not selected, the Dental Office will be assigned.)*

	Employee	Spouse/Domestic Partner	Child	Child	Child
Last Name					
First Name					
Dentist Name/Office					
Dentist I.D. #					
Current Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
City					

☐ Check here if you would like your Dental Plan to assign you a Primary Dental Office.
∅ To enroll more dependents, complete sections A & B on an additional Enrollment Form.

** If changing dental plans or adding a plan, please select a Primary Dental Office. A Primary Dental Office is not required for PPO benefit plans. If a Primary Dental Office is not contracted with your selected Dental Plan prior to enrolling or if a Primary Dental Office is not listed, one will automatically be assigned to you. For Primary Dental Office changes only, please contact your Dental Plan directly.*

D. OPTIONAL BENEFITS - Ask your dental plan administrator if any of the optional benefits below are being offered by your employer

Sections A, B & E of this form must be completed for all Optional Benefits.

Vision: Select ONE plan *(see worksheet for plan availability)*

☐ Platinum ☐ Gold ☐ Silver (Silver not available with VSP Voluntary)

CHIROPRACTIC *(see worksheet for plan availability)*

☐ Check this box to add Voluntary Chiropractic coverage

LIFE

Complete only if your employer has selected life coverage.

Beneficiary Name(s)						
Last Name	First Name	M.I.	Date of Birth	Relationship to You (i.e. spouse, friend, child)	*Percentage	*Type of Beneficiary
			(MM/DD/YYYY)			☐ Primary ☐ Secondary
			(MM/DD/YYYY)			☐ Primary ☐ Secondary
			(MM/DD/YYYY)			☐ Primary ☐ Secondary

* If you are listing more than one primary beneficiary or more than one secondary beneficiary, please enter the percentage of the insurance proceeds that each individual should receive. The percentage of insurance proceeds must equal 100% for each type of beneficiary (primary or secondary). No secondary beneficiaries will be entitled to any part of the insurance proceeds if any primary beneficiary is living at the time of death of the insured.

Premium Only Plan (P.O.P)

☐ I want my portion of eligible insurance premiums paid on a pre-tax basis

E. YOUR LEGAL ACKNOWLEDGEMENT *(Read, sign and date where indicated)*

FOR ALL ENROLLEES:

I agree for myself and my dependents to be bound by the benefits, co-pays, deductibles, exclusions, limitations and other terms of the health plan's small group contract as administered by the state of California.

I declare under the penalty of perjury under the laws of the state of California that the followinsg statements are true, correct and pertain to the employer named on this form, myself and my dependents named on this form.

- I am considered eligible by my employer because I am a full-time employee who works the required number of hours per week.
- If I am an eligible employee applying for coverage outside of a renewal period, I have had a change in family status or have experienced another qualifying/triggering event that qualifies either me or my dependent(s) as a "Late enrollee" pursuant to California law.
- I am not a temporary, seasonal, per diem, 1099 or substitute employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children meet all eligibility requirements. **I understand** that the preceding statements are subject to audit at any time and **agree** to provide ChoiceBuilder® with any and all information necessary to prove the above statements.
- All statements and answers I have given are true and complete. **I understand** it is a crime to knowingly perform an act or practice constituting fraud or make an intentional misrepresentation of material fact to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents. If my plan is rescinded or canceled, I will receive from my insurer a notice at least 30 days to the effective date of the rescission explaining the reasons for the intended rescission and my rights to appeal that decision to the Commissioner of Insurance pursuant to subdivision (b) of Section 10273.4 of the California Insurance Code. Notwithstanding subdivision (a) of Section 10273.4 or any other provision of the law, I understand that after 24 months following the issuance of my health plan or insurance policy, my insurer may not rescind my health plan or insurance policy for any reason, and shall not cancel my health plan or insurance policy, limit any provisions of the health plan or policy, or raise premiums due to any omissions, misrepresentations, or inaccuracies in the application for, whether willful or not.
- **I understand** that any persons, business or health plan that suffers a loss because of false declarations contained in this statement may take legal action against me to recover their losses.
- I authorize any payroll deduction that may be required towards the cost of this coverage.
- The representations made are the basis upon which coverage may be issued.
- California law prohibits HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
- A policy of group health insurance shall provide equal coverage to employers for the registered domestic partner of an employee, insured, or policyholder to the same extent, and subject to the same terms and conditions, as provided to a spouse of the employee, insured, or policyholder, and shall inform employers of this coverage.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

FOR LANDMARK HEALTHPLAN ENROLLEES ONLY:

Terms and conditions of enrollment are described in your Landmark Health Plan of California, Inc. (the "Plan") Combined Evidence of Coverage and Disclosure Form, and the Group Agreement between the Plan and your Employer Group.

In the event that this application for coverage is accepted, I authorize my health care practitioner, as permitted by law, to provide the Plan with information concerning the health condition or treatment of any enrollee named above, as required for the Plan to authorize or pay for covered services provided by such practitioner.

I further authorize the Plan and any other health care plan through which I and/or my dependents have coverage to release any information to one another that would be necessary to coordinate benefits between or among the plans.

With regard to the authorizations above, I agree that a copy of this form shall be valid as the original.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and Landmark Health Plan of California, Inc., or any of its parents, subsidiaries, or affiliates 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 the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

My signature acknowledges both my understanding of the information presented above as well as the decision to enroll in the coverage(s) I have selected.

Signature	Print Name	Date (MM/DD/YYYY)
X		

YOU MUST COMPLETE SECTIONS A-E IN ORDER FOR YOUR FORM TO BE PROCESSED

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DENTAL and/or VISION WAIVER

(for employer sponsored plans only, not required for voluntary plans)

IMPORTANT!

Complete this page only if you DO NOT WANT DENTAL OR VISION COVERAGE for yourself and/or your eligible dependents (if offered by your employer). If sponsored by your employer, the life coverage, chiropractic coverage, or chiropractic/acupuncture coverage cannot be waived and you are required to complete a Dental / Vision / Chiropractic / Life Enrollment Form.

Personal Information

Company Name: WIRELESS WATCHDOGS

Company Phone # (XXX) XXX-XXXX:

Employee Last Name:

Employee Social Security #:

Employee First Name:

Group #: B 0 5 3 5 0

Type of Waiver

I have been offered coverage by my employer, but at this time I wish to DECLINE coverage as follows

1) **Dental for** ☐ Myself and Dependents ☐ Spouse ☐ Domestic Partner ☐ Child(ren)

2) **Vision for** ☐ Myself and Dependents ☐ Spouse ☐ Domestic Partner ☐ Child(ren)

Reason

Required only if employee waiving coverage — not required if waiving coverage for dependents only

1) **Reason waiving Dental**

☐ Other Group Coverage Carrier Name _____
☐ Medicare
☐ Medi-cal
☐ Individual Policy
☐ Other Reason _____ (explanation required)

2) **Reason waiving Vision**

☐ Other Group Coverage Carrier Name _____
☐ Medicare
☐ Medi-cal
☐ Individual Policy
☐ Other Reason _____ (explanation required)

Signature

☒ **I understand that by waiving coverage now, ChoiceBuilder®can impose up to a 12 month period of exclusion which would begin at the time of my later decision to elect coverage.**

☒ I also understand that if my employer is sponsoring life coverage, chiropractic coverage, or chiropractic/acupuncture coverage, that I CANNOT waive these coverages. **(Steps A-E MUST be completed if these benefits are being sponsored.)**

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 60 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Has added a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption and if enrollment is requested within 60 days after the marriage, domestic partnership, birth, adoption or placement for adoption OR employee or eligible dependents loses minimum health care coverage, for any reason other than due to failure to pay premiums, fraud, or intentional misrepresentation of material fact; C) Requests enrollment within 60 days of loss of coverage.

Employee SIGN HERE TO WAIVE COVERAGE	Print Name	Date (MM/DD/YYYY)
♠		

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met
New Spouse/ New Stepchild	If all required documentation is received before the 16th day of the month of marriage, premiums are charged for the full month and coverage begins on the date of marriage. If all required documentation is received on or after the 16th day of the month of marriage, coverage begins on the 1st of the month following the date of receipt.	■ New spouse must be legally married to the employee ■ New stepchild must also meet the dependent children requirements listed below
Birth/Adoption/ Legal Guardianship/ Eligible Dependent Child	If birth/date of placement occurred before the 16th of the month, coverage begins on the first day of the month of the date of birth/placement. If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the first of the following month. Coverage for the dependent begins on the first of the month following the birth/date of placement.	■ Born to, a stepchild or legal ward of, adopted by eligible employee, employee spouse or domestic partner ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **Disabled Dependents:** Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday. **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner/ Child of Domestic Partner	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month. Mid-Year Addition: Mid-year additions of a domestic partner will require a state-stamped copy of the Declaration of Domestic Partnership from the California Secretary of State within 60 days of issuance. If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted. Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance. If all required documentation is received before the 16th day of the month in which the domestic partnership was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month in which the domestic partnership was established, coverage begins on the 1st of the month following the date of receipt.	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ Both have filed a duly executed Declaration of Domestic Partnership with the Secretary of State and will provide copies to ChoiceBuilder® within 60 days of its issue. ■ Agree to notify ChoiceBuilder immediately upon termination of domestic partnership. Children of Domestic Partner must also meet the dependent children requirements listed above **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**