DHMO ENROLLMENT APPLICATION

Please complete in black ink.

Effective Date: _____
Source Code: _____

Coverage Type: ❑ DHMO PA1 ❑ DHMO PA2 ❑ DHMO PA3 ❑ DHMO PA4

Subscriber Information

Social Security Number: _____ Primary Language: _____
Last Name: _____ First Name: _____ MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____)_____ E-mail Address: _____
Date of Birth: _____ Sex: ❑ M ❑ F Married? ❑ Yes ❑ No Children? ❑ Yes ❑ No

MUST BE COMPLETED TO ENROLL IN PLAN *Primary Care Dentist Choice: I understand that I must select a Premier Access Contract Dentist from the list of facilities as my assigned Primary Care Dentist. If the selected facility is not available, non-contracted or closed to further enrollment, Premier Access reserves the right to assign me to another dental office as close as possible to my home. In the event that I cannot be assigned to a Primary Care Dentist, my Premium will be refunded.*

Primary Care Dentist Facility Choice 1 _____ Primary Care Dentist Facility Choice 2 _____

Dependent Information

** Dependent children are eligible for coverage to age 26. Dependent children age 26 or over remain eligible if unmarried and incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition and is chiefly dependent on the Subscriber for support.

Relation to Subscriber	Last Name	First Name & MI	Date of Birth**	Sex (M/F)	Disability (Y/N)	Primary Care Dentist Office ID #	Primary Care Dentist ID #
Spouse or Registered Domestic Partner							
Child							
Child							
Child							
Child							

DHMO PA1 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

DHMO PA2 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

DHMO PA3 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

DHMO PA4 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

Select Your Payment Method (check one) ❑ Annual Credit Card ❑ Annual Check/Money Order ❑ Monthly Credit Card Draft ❑ Monthly Bank Draft

CREDIT CARD INFORMATION - PLEASE CHARGE MY (check one)

❑ VISA ❑ Mastercard ❑ Discover ❑ American Express

Name as it appears on card: _____
Credit Card Number: _____
Expiration Date: _____

Authorization/Signature: _____ Date: _____

BANKING INFORMATION - PLEASE CHARGE MY (check one)

❑ Checking Account (include a voided check) ❑ Savings Account (include a voided deposit slip)

I hereby authorize Premier Access to debit the designated prepayment fee each month from the bank account indicated above. I understand that the amount of my monthly prepayment fee will be deducted from my account and that there will be a [$25] service charge for any returned drafts.

Authorization/Signature: _____ Date: _____

This enrollment form with signed authorizations and/or check or money order, as applicable, must be received by the 20th of the month for your coverage to be effective the first of the following month. Return enrollment form to **Premier Access at P.O. Box 659005, Sacramento, CA 95865-9005** or fax to: **877.648.7748** or enroll online at **WWW.PREMIERLIFE.COM**

Mandatory Binding Arbitration I understand that any dispute or contracting that may arise between me and Premier Access shall be submitted to binding arbitration held in accordance with the commercial arbitration rules of the American Arbitration Association in lieu of a jury or court trial, and that should any dispute arise, neither Premier Access or I may pursue any claims as a plaintiff or class member in any purported class or representative proceeding, and instead must pursue any such claims in an individual capacity. Both Premier Access and I expressly waive any right to initiate or arbitrate a class action against one another relative to any disputes relating to or arising in any way out of my enrollment with Premier Access or its affiliates. The arbitration proceeding will take place in Sacramento, California or, if that location is prohibitive or significantly inconvenient to the parties, at an alternative location selected by the American Arbitration Association.

Agency ID # 21447 **Broker ID # 11968**

Employee Signature: _____ **Date:** _____

To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this application. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if I made false statements with the intent to deceive or that has a material effect on the policy coverage and/or premium.

Dependent Only Enrollment: I understand that if I have indicated that coverage under the Plan is to be provided only for the dependent child(ren) named on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form/ Contract.

Authorization: I hereby authorize my medical or dental care institution or professional to release to a representative of Premier Access, any personal, privileged or medical records information including but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Premier Access provider agreements or local, state, or federal laws. This authorization is valid for the duration of coverage.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE. THEREFORE, PREMIER ACCESS INSURANCE COMPANY 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, PREMIER ACCESS INSURANCE COMPANY COMPLIES IN ALL RESPECTS WITH THE PROHIBITION AGAINST THE UNAUTHORIZED DISCLOSURES OF AN HIV TEST.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided.

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. In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Premier Access' ratio of health care expenses to premiums received for the last calendar year with respect to the Premier Access Individual & Family Plans was 60.0%.

Please note any communication assistance or special needs: _____

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* DHMO benefit plans are underwritten by Access Dental Plan, Inc. of CA, a Premier Access company and a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.