CoPower
Administrators

# DENTAL ENROLLMENT / CHANGE FORM

To be filled out by Employee

**POLICY INFORMATION**

| Company / Group Name | CoPower ID# | Dental Plan (check one) | *For CoPower Use Only* |
|---|---|---|---|
| Haulsey Engineering, Inc. | 46823 | ☐ Premier ☒ PPO ☐ HMO | *CPS#:* |

**REASON FOR ADDITION / CHANGE (check one)**

- ☐ **New Hire** (eligible first of the month following wait period)
- ☐ **Part-time to Full-time** (give date of hire and full-time start date)
- ☐ **Dependent Change** (provide reason & date of qualifying event)
- ☐ **Loss of Coverage** (provide proof – letter from prior carrier/employer)
- ☐ **Fed-COBRA Enrollment** (provide termination date)
- ☐ **Name or SS# Change** (provide old and new name or SS#)
- ☐ **Address Change** (HMO members only)
- ☐ **Open Enrollment** (only available with HMO option B for late enrolling dependents or option C for late enrolling employees and dependents)
- ☐ **Other** (please explain)

| Comments: | Effective Date: |
|---|---|
| | |

**ENROLLEE INFORMATION**

| Enrollee Name (Last Name, First Name) | Social Security Number | Gender | Date of Birth | Date of Hire |
|---|---|---|---|---|
| , | | ☐ M ☐ F | | |

**DEPENDENTS TO BE ENROLLED / CHANGED**

| Spouse / Domestic Partner Name (Last, First) | Action | Gender | Date of Birth | |
|---|---|---|---|---|
| , | ☐ Add ☐ Term | ☐ M ☐ F | | |
| **Child Name (Last, First)** | **Action** | **Gender** | **Date of Birth** | **If 19 years or older check one:** |
| , | ☐ Add ☐ Term | ☐ M ☐ F | | ☐ Full-Time Student Under 25 ☐ Disabled |
| , | ☐ Add ☐ Term | ☐ M ☐ F | | ☐ Full-Time Student Under 25 ☐ Disabled |
| , | ☐ Add ☐ Term | ☐ M ☐ F | | ☐ Full-Time Student Under 25 ☐ Disabled |
| , | ☐ Add ☐ Term | ☐ M ☐ F | | ☐ Full-Time Student Under 25 ☐ Disabled |

**HMO (DELTACARE) ENROLLEES MUST FILL OUT THIS SECTION**

| Member Mailing Address | City | State | Zip | Phone |
|---|---|---|---|---|
| | | | | |

| Provider Choice: Dental Office ID# | Dental Office City | Dental Office Name |
|---|---|---|
| | | |

**SIGNATURE**

| Enrollee Signature | Date |
|---|---|
| | |

**Please fill out completely – any missing information could delay processing your enrollment.**

477 Ninth Avenue, Suite 102, San Mateo, CA 94402 • **www.copower.com** • Phone: 888.920.2322 Fax: 650.348.1149