DPC DENTAL PRACTICE consortium

IDA INSURANCE trust

Benefit Application

The Dental Practice Consortium is a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of the State of Indiana. State insurance guaranty funds are not available for the Dental Practice Consortium.

EMPLOYER/GROUP INFORMATION

EMPLOYER/GROUP NAME:

OTHER DDS IN PRACTICE:

EMPLOYER ADDRESS:

PHONE #:

E-MAIL:

OFFICE TAX ID:

EFFECTIVE DATE:

REASON FOR APPLICATION: ☐ Open Enrollment ☐ Waiver ☐ New Enrollment ☐ New Hire ☐ Birth ☐ Marriage ☐ Adoption

MEDICAL COVERAGE: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ Waive Coverage

VISION COVERAGE: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ Waive Coverage

EMPLOYEE INFORMATION

LAST NAME: **MIDDLE INITIAL:** **FIRST NAME:** ☐ Female ☐ Male

DATE OF BIRTH: **AGE:** **SS #:** **HEIGHT:** **WEIGHT:**

HOME ADDRESS:

PERSONAL PHONE #: **E-MAIL:**

ARE YOU CURRENTLY: **Retired** ☐ Yes ☐ No **Disabled** ☐ Yes ☐ No **Hospitalized** ☐ Yes ☐ No

HRS. WORKED **OCCUPATION:**

DEPENDENT INFORMATION

LAST NAME: **MIDDLE INITIAL:** **FIRST NAME:** ☐ Female ☐ Male

DATE OF BIRTH: **AGE:** **SS #:** **HEIGHT:** **WEIGHT:**

ARE YOU CURRENTLY: **Disabled** ☐ Yes ☐ No **Hospitalized** ☐ Yes ☐ No **Court Ordered To Provide Health Coverage** ☐ Yes ☐ No **RELATIONSHIP:** ☐ Spouse ☐ Child ☐ Other

LAST NAME: **MIDDLE INITIAL:** **FIRST NAME:** ☐ Female ☐ Male

DATE OF BIRTH: **AGE:** **SS #:** **HEIGHT:** **WEIGHT:**

ARE YOU CURRENTLY: **Disabled** ☐ Yes ☐ No **Hospitalized** ☐ Yes ☐ No **Court Ordered To Provide Health Coverage** ☐ Yes ☐ No **RELATIONSHIP:** ☐ Spouse ☐ Child ☐ Other

LAST NAME: | MIDDLE INITIAL: | FIRST NAME: | ☐ Female ☐ Male

DATE OF BIRTH: | AGE: | SS #: | HEIGHT: | WEIGHT:

ARE YOU CURRENTLY: Disabled ☐ Yes ☐ No | Hospitalized ☐ Yes ☐ No | Court Ordered To Provide Health Coverage ☐ Yes ☐ No | RELATIONSHIP: ☐ Spouse ☐ Child ☐ Other

LAST NAME: | MIDDLE INITIAL: | FIRST NAME: | ☐ Female ☐ Male

DATE OF BIRTH: | AGE: | SS #: | HEIGHT: | WEIGHT:

ARE YOU CURRENTLY: Disabled ☐ Yes ☐ No | Hospitalized ☐ Yes ☐ No | Court Ordered To Provide Health Coverage ☐ Yes ☐ No | RELATIONSHIP: ☐ Spouse ☐ Child ☐ Other

PRIOR HEALTH COVERAGE

DO YOU CURRENTLY HAVE HEALTH COVERAGE?: ☐ Yes ☐ No | CARRIER NAME: | POLICY #:

LIST THOSE COVERED BY PREVIOUS PLAN:

HAVE YOU BEEN COVERD BY ANTHEM WITHIN THE PAST 2 YEARS?: ☐ Yes ☐ No | POLICY #: | DATES COVERED:

MEDICAL INFORMATION

Are you or any dependents currently taking medications?: ☐ Yes ☐ No

Has a physician told you or any of your dependents that surgery or special treatment may be necessary in the future? ☐ Yes ☐ No

In the last 5 years, have you or any of your dependents been diagnosed with the following:

Cancer/Tumor	☐ Yes	☐ No
Disorder of the blood or immune system	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Aneurysm	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Mental/Nervous Disorder	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Alcohol or Drug Abuse	☐ Yes	☐ No
Kidney, Liver or Pancreas Disorder	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No
Ulcerative Colitis	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Lung Disorder (COPD or emphysema)	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Back Disorder	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No

In the past 5 years, have you or any of your dependents been diagnosed with HIV or AIDS?: ☐ Yes ☐ No

Have you or any of your dependents visited the ER on 2 ore more occurrences for the same condition in the past 12 months?: ☐ Yes ☐ No

Have you or any of your dependents used tobacco or vape products of any kind, in the past 12 months?: ☐ Yes ☐ No

Are you or any of your dependents currently pregnant?: ☐ Yes ☐ No

If yes, what is the projected due date?:

To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis or treatment for the following:

IBS, hernia, diverticulitis or any other intestinal disorder	☐ Yes	☐ No
Thyroid, goiter or gallbladder disorders	☐ Yes	☐ No
High blood pressure, chest pain, heart murmur or disorder of the veins/circulatory system	☐ Yes	☐ No
Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints	☐ Yes	☐ No
Epilepsy, convulsions, paralysis or disorder of the brain or nervous system	☐ Yes	☐ No
Asthma, allergies, sinus or disorder of the respiratory system	☐ Yes	☐ No
Any STD or disorder of the prostate, genital, reproductive or urinary system	☐ Yes	☐ No
Any disorder of the skin, ears or eyes	☐ Yes	☐ No

Have you or any of your dependents within the past 2 years, engaged in skydiving, hang gliding, underwater diving, racing, rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated in the near future? ☐ Yes ☐ No

Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years?: ☐ Yes ☐ No

For all 'yes' responses- please provide additional information on Page 3 of this application "Medical Information Continued".

MEDICAL INFORMATION- CONTINUED

NAME	DIAGNOSIS	TREATMENT/MEDICATION	DATES OF TREATMENT
PHYSICIAN'S NAME	**HOSPITALIZED?**	**SURGERY?**	**RECOVERED?**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

NAME	DIAGNOSIS	TREATMENT/MEDICATION	DATES OF TREATMENT
PHYSICIAN'S NAME	**HOSPITALIZED?**	**SURGERY?**	**RECOVERED?**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

NAME	DIAGNOSIS	TREATMENT/MEDICATION	DATES OF TREATMENT
PHYSICIAN'S NAME	**HOSPITALIZED?**	**SURGERY?**	**RECOVERED?**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

LIFE INSURANCE- BENEFICIARY INFORMATION

NAME	RELATIONSHIP TO INSURED	SS#:	%:

SIGNIFICANT TERMS, CONDITIONS & AUTHORIZATIONS

1. I agree that I am responsible to ensure that the required premium is paid for coverage to the Dental Practice Consortium. If applicable, I authorize my employer to deduct the required premium for medical coverage.
2. I am responsible to notify my employer (if applicable) and the Dental Practice Constortium immediately if my spouse, my dependents or I become ineligible for the medical plan offered through the Dental Practice Consortium.
3. I understand that the Dental Practice Consortium is a multiple employer welfare arrangement. The Dental Practice Consortium may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for the Dental Practice Consortium.
4. I understand that any health information provided on this form may be utilized by the Dental Practice Consortium for purposes of establishing a health factor rating for similarly situated individuals working for the same dental practice or other participating employer.
5. I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge. I understand that my answers are being relied upon by the Dental Practice Consortium and its insurance providers. Any fraud or intentional misrepresentation of material fact may result in rescission of coverage or other appropriate relief.

By signing this document, I am indicating that I have read and understand the language in the Significant Terms, Conditions & Authorizations section of this application and agree to all the terms and conditions.

SIGNATURE:	DATE:

By signing below, I certify that I was offered benefits with the Dental Practice Consortium and that I am WAIVING coverage for the benefits offered.

NAME OF EMPLOYEE WAIVING COVERAGE	EMPLOYER'S NAME	SIGNATURE	DATE SIGNED