UNITED CONCORDIA® DENTAL

Please send to: **Dependent Certification**
United Concordia Companies
4401 Deer Path Road
Harrisburg PA 17110
Fax number: 1-800-329-9093

DEPENDENT CERTIFICATION FORM

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent. **Incomplete or illegible forms will be returned to the sender, resulting in delayed processing.**

SECTION A: GENERAL INFORMATION

1. Name of Employee (print - last, first & middle initial)

2. Contract ID Number (Such as SSN)

3. Employee's Address (number, street, city, state & zip code)

4. Dependent Name (print - last, first & middle initial)

5. Dependent's Birthdate (mm/dd/year) __ __

6. Dependent's Relationship to Employee
☐ Son ☐ Daughter ☐ Other

7. Dependent's Marital Status
☐ Single ☐ Married

If dependent is married, provide date of marriage (mm/dd/year)

8. Is dependent currently covered under a medical plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

9. Is dependent currently covered under another dental plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

SECTION B: STUDENT DEPENDENT CERTIFICATION *(To be completed by Employee)*

1. Name of school in which dependent is enrolled

2. Type of school (i.e., college, trade, etc.)

3. Student enrolled
☐ Full-Time ☐ Part-Time ☐ Post-Graduate

_____ Number of Credits

Will the dependent be graduating within 12 months?
☐ **Yes** ☐ **No**

If "Yes," please provide the expected graduation date: _____

Failure to provide the expected graduation date may result in delayed processing and/or termination of dependent coverage.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Employee | Phone Number | Email Address | Date Signed

SECTION C: DISABLED DEPENDENT CERTIFICATION *(To be completed by Physician)*

1. Is dependent now incapable of self-support because of a disability?
☐ Yes ☐ No

2. Dependent's age when disability occurred

3. Nature of disability (please provide as much detail as possible)

4. Prognosis (estimate in months or years)

5. Name of Primary Care Physician (print or type)

6. Address of Physician (print or type)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Physician | Date Signed

SECTION D: DEPENDENT NO LONGER ELIGIBLE *(To be completed by Employee)*

PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE IF YOUR INELIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE.

I ACKNOWLEDGE THAT THE DEPENDENT LISTED ABOVE IS NO LONGER ELIGIBILE FOR BENEFITS AS A DEPENDENT ON MY UNITED CONCORDIA DENTAL CONTRACT.

Signature of Employee | Ineligible Effective Date | Date Signed

Discrimination is Against the Law
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nế u quý vị nói Tiế ng Việ t, chúng tôi có các dị ch vụ hỗ trợ ngôn ngữ miễ n phí dành cho quý vị . Gọ i số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366（TTY: 711）まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید.