Cypress DENTAL

Group Insurance Enrollment/Change Form

Underwritten by
Cypress Dental Insurance Company of California
7510 Shoreline Drive
Stockton, California 95219
Phone 800-350-3989

Please print and complete all sections. Send to: enrollment@cypressadmin.com

Group Name	Department/Location	Group Number	Date of Hire	Effective Date/Change

EMPLOYEE INFORMATION ☐ Apply/Add (enroll) ☐ Terminate ☐ Change (change of name, address, phone or coverage)

First Name	MI	Last Name
Gender ◯ M ◯ F ◯ Other	Date of Birth	Social Security Number
Home Street Address		
City	State	Zip
Cell Phone Number ( )	Work Phone Number ( )	DHMO ONLY Facility #
Email Address		

FAMILY INFORMATION **ADD** = Apply/Add (enroll) **TERM** = Terminate **CHG** = Change (change of name, address, phone or coverage)
For more Dependents, use a separate sheet of paper, signed and dated.

	Gender	First Name	MI	Last Name	Date of Birth	Handicapped	DHMO ONLY
◯ ADD ◯ TERM ◯ CHG	☐ M ☐ F ☐ Other	First Name (Spouse or Domestic Partner)	MI	Last Name	Date of Birth	☐ Y ☐ N	Facility #
◯ ADD ◯ TERM ◯ CHG	☐ M ☐ F ☐ Other	First Name (Dependent)	MI	Last Name	Date of Birth	☐ Y ☐ N	Facility #
◯ ADD ◯ TERM ◯ CHG	☐ M ☐ F ☐ Other	First Name (Dependent)	MI	Last Name	Date of Birth	☐ Y ☐ N	Facility #
◯ ADD ◯ TERM ◯ CHG	☐ M ☐ F ☐ Other	First Name (Dependent)	MI	Last Name	Date of Birth	☐ Y ☐ N	Facility #
◯ ADD ◯ TERM ◯ CHG	☐ M ☐ F ☐ Other	First Name (Dependent)	MI	Last Name	Date of Birth	☐ Y ☐ N	Facility #

COVERAGE ELECTED: I elect the following coverage(s):

	DENTAL PPO	DENTAL DHMO	NONE	VISION Verify your employer has purchased vision through Cypress
Employee Only	☐	☐	☐	☐
Employee + Spouse (or EE+1)	☐	☐	☐	☐
Employee + Child(ren)	☐	☐	☐	☐
Employee + Family (or EE+2 or more)	☐	☐	☐	☐
Waived due to other coverage	☐	☐	☐	☐
Waive ____________________	☐	☐	☐	☐

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

Employee Signature: ______________________________ **Date:** ______________

Mandatory Binding Arbitration: Cypress Dental uses binding arbitration to settle disputes, including to settle claims of dental malpractice. The insured understands and agrees that if a dispute arises in connection with this policy, the parties waive the right to a jury or court trial and must settle the dispute through binding arbitration held in accordance with the commercial arbitration rules of the American Arbitration Association. Should any such dispute arise, both Cypress Dental and the insured agree that any claims must be pursued in the party's individual capacity, and not as a plaintiff or class member in any purported class or representative proceeding. The Cypress Dental Certificate of Insurance contains a provision that further addresses this issue. Cypress Dental does not use binding arbitration in connection with any dispute involving an insured's life insurance coverage.

FRAUD WARNING NOTICE

Any person who, with intent to defraud or knowing that he or 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. The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.