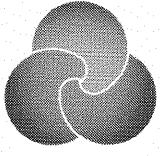
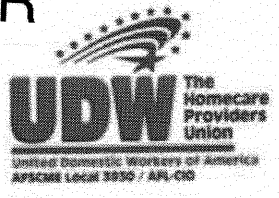


Please send a \$3.00 check or money order payable to UDW to pay for 1st month!

OVER



Dental Health Services Enrollment Form Formulario de Inscripción



Effective Date / Fecha Efectiva de Cambio Preferred Language/Idioma Preferido

Employee information / Información del empleado

Social Security # # Seguro Social

Name/Nombre Address/Dirección City/Ciudad State/Estado Zip Code/Zona Postal Phone Number/Número de Teléfono Email/Correo Electrónico Date of Birth/Fecha de Nacimiento Gender/Sexo

Company information / Información de su empleador

Company Name/Nombre de la Compañía UDW San Diego - Trust Administration Office Group Number/Numero de Grupo 3977H Address/Dirección 940 Calle Negocio #110 City/Ciudad San Clemente State/Estado CA Zip Code/Zona Postal 92673 Date of Hire/Fecha de Emplea

Dentist Number / Numero de dentista

Enrollment Information / Información de su plan

X Employee only Empleado

For dental benefit questions call - 877.890.7023 For eligibility questions call our trust administration office - 800.883.0902

Please return this application to UDW San Diego Trust Administration Office 940 Calle Negocio #110 San Clemente, CA 92673

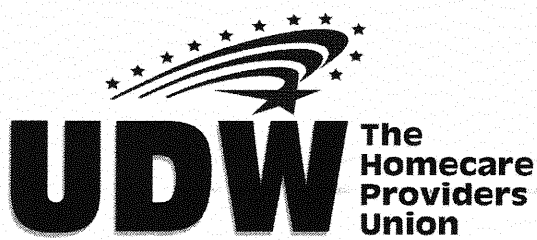
I hereby request coverage and authorize payroll deductions (if applicable) from my earnings for any contributions required for a minimum of one year. Authorization is granted to release my patient history to Dental Health Services, consulting health professional, or other entity designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. This authorization remains in effect until revoked by me in writing / En representación de mí mismo y de mis dependientes elegibles, por la presente solicito cobertura dental que he indicado de Dental Health Services y que me fuera ofrecido a través de mi empleador. Coincido las deducciones en la nómina (si aplica) de mi salario para la contribución adecuada el mínimo de un año. Coincido dar la autorización para conceder información relacionada con mi historia médica a Dental Health Services, consultante profesional medica u otra entidad aprobada por Dental Health Services para el propósito de certificar, evaluar o administrar beneficios. Esta autorización es efectiva hasta que sea revocada por mi escrito.

By signing this dental enrollment application I am agreeing to a \$3 monthly payroll deduction for this dental plan.

Employee signature/Firma del empleado Date/Fecha

1G046

Official Use Only Authorized by Group Number 3977H Date



United Domestic Workers of America  
AFSCME Local 3930 /AFL-CIO

**SAN DIEGO DENTAL INSURANCE QUESTIONNAIRE**  
(This form must be returned with your enrollment forms to be enrolled)

YOUR NAME (as if appears on your state payroll check):

\_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

AUTHORIZED HOURS PER MONTH FOR ALL CLIENTS: \_\_\_\_\_

DATE OF HIRE FOR FIRST CLIENT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

PLEASE CHECK ALL OF THE FOLLOWING (if they apply):

- I am currently working a minimum of 80 hours per month and I understand that I must maintain minimum working hours of 80 paid hours per month to remain eligible for dental insurance
  
- I understand and agree to pay through payroll deduction or by invoice a \$3.00 monthly premium co-pay for my dental insurance and failure to do so will result in losing dental benefits. You will be canceled from the dental benefits if you have one un-paid invoice for more than 30 days.

Please note: If your hours drop below 80 hours worked per month because of your illness or your client is hospitalized, etc., please let us know immediately. Call our San Diego County Trust Administration office at (800)-883-0902 – Goldman & Walker Insurance Services, LLC.

**RETURN THIS QUESTIONNAIRE AND THE DENTAL ENROLLMENT FORM IN THE SELF ADDRESSED ENVELOPE ASAP. WE ARE CURRENTLY RUNNING A WAITING LIST FOR YOUR DENTAL BENEFITS**