GEHA

How to enroll in Connection Dental Plus

To enroll, you must currently or previously be eligible for FEHB benefits. Eligible dependents are your legally married spouse and each unmarried child under age 26.

Choose one of the four coverage options:

1) Self Only	**2)** Self and Family
3) Self Plus One	**4)** Dependent only (age 22 – 25)

Please follow these steps to enroll:

1) Complete the Enrollment Application.
2) Select your payment option:
   a. Option 1: Monthly/quarterly bank draft from your checking or savings account
   b. Option 2: Quarterly, semi-annual, or annual billing by GEHA
3) Enclose a check or money order payable to GEHA Connection Dental Plus for your first premium payment. A premium payment isn't required if you choose a bank draft. Please refer to the Premium Rate Codes by state and ZIP code.
4) If you choose to pay by bank draft, complete the **Bank Draft Authorization form**. If you choose to be billed by GEHA, you may pay by check, credit card or money order. Please pay online at **geha.com/Payment**.
5) Return your completed Enrollment Application, your first premium payment and your **Bank Draft Authorization form** (if applicable) in a postage-paid envelope.

How to find an in-network dentist:

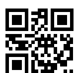
1) Visit **geha.com/Find-Care**
2) Click Find a Dentist.
3) After completing the required information, a list of in-network dentists will display.
4) Or, call Customer Care at **800.296.0776** to request a list of in-network dentists.

When coverage takes effect:

If you meet the enrollment requirements, your coverage will be effective on the first day of the month following receipt of your application and a first premium payment.

After enrollment:

1) After your application is processed, you will receive your Connection Dental Plus ID cards in the mail.
2) Present your ID cards to your dentist before receiving care.
3) Your card has the claim filing address and important numbers for you and your dentist.



GEHA

Connection Dental Plus Enrollment Application

Please complete this page in full, sign your name and date. To enroll, mail to GEHA in the enclosed postage-paid envelope and include your; 1) initial premium payment if paying by billing from GEHA or 2) completed **Bank Draft Authorization form** (if applicable). Please see the premium rate schedule to determine your correct premium payment. **All fields are required.** Incomplete information may delay processing and your effective date of coverage.

CURRENT OR FORMER FEDERAL EMPLOYEE, SURVIVOR ANNUITANT OR OVERAGE DEPENDENT OF PARENTS FEDVIP PLAN

GEHA ID Card Number OR Enrollee Social Security number:			
First name:	Middle initial:	Last name:	
Physical address:	Date of birth: (MM/DD/YY)	Married: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female
City:	State:	ZIP code:	Phone number:
Mailing address: (if different than physical address)		Email address:	
Name of federal agency employed, retired, or formerly employed by:		Social Security number:	

SELECT COVERAGE OPTION

☐ Self Only	☐ Self Plus One Dependent	☐ Self and Family	☐ Dependent Only (age 22 to 25)

DEPENDENT COVERAGE INFORMATION

Relationship code: (1=spouse, 2=child, 3=other)	First name:	Middle initial:	Last name:	Gender:	Date of birth: (MM/DD/YY)	Social Security number:
				☐ Male ☐ Female		
				☐ Male ☐ Female		
				☐ Male ☐ Female		
				☐ Male ☐ Female		

SELECT ONE PAYMENT OPTION (Please enclose initial premium payment.)

☐ Bank draft from checking account ☐ Monthly ☐ Quarterly	☐ Bank draft from savings account ☐ Monthly ☐ Quarterly	☐ Billing from GEHA ☐ Quarterly ☐ Semi-annual ☐ Annual

OTHER COVERAGE INFORMATION

My Federal Employees Health Benefits plan is/will be:		Enrollment code:
Do you, your spouse or any other eligible dependent(s) have dental coverage, other than the FEHB plan listed above? ☐ Yes ☐ No		
If yes, list name of insurance:	Effective date:	☐ Self Only ☐ Self Plus Family
Insurance carrier's phone number:		
Policy holder:	Covered family members:	

I have read and understand the information on the reverse side of this form. I hereby apply for coverage for myself and my eligible dependent(s), if any. The information provided above is true and correct to the best of my knowledge.

Signature: Date: