How to enroll in Connection Dental *Plus*

Choose one of three coverage options:

A Self Only **B** Self and One Dependent **C** Self and Family

To enroll, you must currently or previously be eligible for FEHB benefits. Eligible dependents can be enrolled only if the current or former federal employee or annuitant enrolls. Eligible dependents are your legally married spouse and each unmarried child who is under age 26.

It's easy to enroll:

1 Complete the **Enrollment Application** in this brochure.

2 Select your payment option:

- monthly/quarterly bank draft from checking or savings account.

or

- quarterly, semi annually or annually billing by GEHA.

3 Enclose a check or money order payable to GEHA Connection Dental *Plus* for your first month premium payment. (This is required even when choosing bank draft.) Refer to the **Premium Rate Codes by State/Zip Code**.

4 If you choose to pay by bank draft, complete the **Bank Draft Authorization Form** on page 5 of this brochure.

4 If you choose to be billed by GEHA, you may pay by check, credit card, or money order. We will send your statement on a quarterly basis.

5 Return your completed **Enrollment Application** (page 3), your first premium payment and your **Bank Draft Authorization Form** (if applicable) in the enclosed postage-paid envelope.

How to find an in-network dentist:

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

When coverage takes effect

If you meet all enrollment requirements, your coverage will be **effective on the first day of the month following receipt of your Enrollment Application and first month premium payment by check, credit card, or money order**.

After enrollment

1) After we process your Enrollment Application, we will mail your Connection Dental *Plus* identification cards to you.
2) Always present your Connection Dental *Plus* identification card to the dentist before you receive care.
3) Your card will show the claim filing address and important toll-free numbers for you and your dentist.

GEHA Connection Dental Plus

Attn: Connection Programs
P.O. Box 21542
Eagan, MN 55121-9930
800.793.9335
geha.com/cdplus

4D

Eff Date: _____ Subgroup: _____

Coverage: _____ Rate Area: _____

Pymt Option: _____ Premium: _____

Amt Recd: _____CK MO CC

Initials: _____ Date: _____

Internal Use Only

ENROLLMENT APPLICATION

INSTRUCTIONS: Please print using a ballpoint pen. Complete this page in full, sign your name and date. Mail to GEHA in the enclosed postage-paid envelope and include your; 1) initial premium payment and 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.

MEMBER OR SURVIVOR ANNUITANT INFORMATION

GEHA ID CARD NUMBER **OR** SOCIAL SECURITY NUMBER OF FEDERAL EMPLOYEE ----------→

First Name | Middle Initial | Last Name

Physical Address | Birth Date MM/DD/YY | Married ☐ YES ☐ NO | ☐ MALE ☐ FEMALE

City | State | ZIP | Daytime Phone ( )

Mailing Address If Different Than Physical Address

Name of Federal Agency Employed/Retired /Formerly Employed by | ☐ ACTIVE ☐ RETIRED ☐ FORMER | **SURVIVOR ANNUITANT**, Put Your Social Security Number Here

SELECT COVERAGE OPTION

☐ **Self Only** ☐ **Self and One Dependent** ☐ **Self and Family**

DEPENDENT COVERAGE INFORMATION (Relationship Codes: 1=spouse 2=natural child 3=other, specify)

RELATIONSHIP CODE	FIRST NAME	MIDDLE INITIAL	LAST NAME (IF DIFFERENT)	GENDER M/F	DATE OF BIRTH MM/DD/YY	ZIP CODE (If Different)	SOCIAL SECURITY NUMBER

SELECT ONE PAYMENT OPTION (Please enclose initial premium payment)

☐ **Bank Draft from Checking Account**
(Complete Bank Draft Authorization Form)
◯ Monthly ◯ Quarterly

☐ **Bank Draft from Savings Account**
(Complete Bank Draft Authorization Form)
◯ Monthly ◯ Quarterly

☐ **Billing from GEHA**
◯ Quarterly
◯ Semi-Annually ◯ Annually

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 medical or dental coverage, other than the FEHB plan listed above? ☐ YES ☐ NO

If yes, list name of insurance _____ Effective date of policy _____ ☐ SELF ONLY ☐ FAMILY

Insurance phone # _____

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: _____

Please allow us 3 to 4 weeks to process your application and mail your ID cards.

(over)