



Please send completed form to:
 Healthplex Insurance Company
 Attention: Sales & Marketing
 333 Earle Ovington Blvd., Suite 300
 Uniondale, NY 11553-3608
 P 800-468-0466 F 516-228-9572

PEDIATRIC "OFF-EXCHANGE" GROUP ENROLLMENT FORM

EMPLOYER/GROUP INFORMATION				
Employer/Group Name				
Group Number		Effective Date		
EMPLOYEE INFORMATION				
Employee Last Name	Employee First Name		M.I.	SSN
Address		City	State	Zip Code
Home Phone		Email Address		
PEDIATRIC MEMBERS				
Last Name, First Name	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
Last Name, First Name	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
Last Name, First Name	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
Last Name, First Name	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
Last Name, First Name	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
Last Name, First Name	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
Last Name, First Name	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
PRIMARY CARE DENTIST (PCD) SELECTION				
<p><i>Please choose one Primary Care Dentist (PCD) from the Exchange Net Provider Network. If no selection is made, a PCD will be assigned nearest your home. To view available dentists in the network, visit www.healthplex.com and select "Our Dentists" then "New York State Health Exchange".</i></p>				
Dentist Name		Dentist Site Code		
<p><i>By signing below, I affirm that I am employed by the above-referenced employer/group and I am the parent/guardian of the pediatric member(s) listed herewith. I have read and agreed to the terms and conditions on the back of this form. I understand that my employer/group is responsible for the payment premium due to Healthplex Insurance Company for pediatric dental coverage.</i></p> <p><i>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</i></p>				
Employee Signature			Date	



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TERMS & CONDITIONS

BENEFITS

I understand that the In-Network benefits insured by Healthplex Insurance Company are only available at participating dental offices and that there are no Out-of-Network benefits.

NEW YORK STATE REGIONS AND COUNTIES

REGION	COUNTIES
Albany	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Buffalo	Allegany, Cattaraugus, Chautaugua, Erie, Genesee, Niagara, Orleans, Wyoming
Mid-Hudson	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
NYC	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Rochester	Livingston, Monroe, Ontario, Seneca, Wayne, Yates
Syracuse	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins
Utica	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence
Long Island	Nassau, Suffolk