Detach and send to: Unum Dental HMO Plan | 10700 Civic Center Dr. Ste 100-A | Rancho Cucamonga, CA 91730 Toll Free: (800) 937-3400 Fax: (909) 483-5351

New Subscriber Application | *Must be compelted in full

Last Name*	First Name*	M.I.	Social Security

Address (Must be complete)*	City*	State*	Zip Code*

Date of Birth*	Phone Number*	E-mail Address	Language Preference	Gender

Choose Your Dentist

Dentist Selection # _____ *from our provider list*

Plan Selection _____

Type Selection: Monthly

Agent Info#: N/A

Choose one Option & Premium

Plan Premium Tiers

- ☐ Subscriber
- ☐ Subscriber & 1 dependent*
- ☐ Subscriber & 2+ dependents*

*Complete dependent Information *(if any)* on back side of this application

Choose Your Start Date

Plan Effective Date: /01/20__

For immidiate coverage select current month.
Coverage must always begin on the 1st of a month.

Choose one that applies:

- ☐ New Memeber
- ☐ Re-instate Member
- ☐ Add or Removed Dependents. Date:_____

Group Information:

Group Number:_____

Name: _____

Contact: _____

Phone: _____

By signing I apply to become a subscriber upon acceptance of my application by Starmount Managed Dental of California dba. Unum Dental HMO Plan I understand this is a contract with Unum Dental HMO Plan.

_____

Signature Date

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Dependent Information | *Must be compelted in full

Last Name	First	M.I.	Date of Birth	Relationship	Gender	*If applicable:* Add or Remove?