

ENROLLMENT FORM

Please print. Complete form to ensure enrollment.

Employer Group Name		Delta Dental Group Number		Date of Hire		Location No. (if applicable)	
Social Security No. / Subscriber I.D. No.		Subscriber Name: First (8 Characters) Last (16 Characters)					
Date of Birth		Street Address / P.O. Box No.					
Effective Date of Action:		Apt. No.		City		State	Zip
QUALIFYING EVENT <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> New Hire <input type="checkbox"/> Family Medical or Disability Leave <input type="checkbox"/> Marriage <input type="checkbox"/> Spouse's Loss of Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Full Time/Part Time Status <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Death of a Member				DEPENDENT INFORMATION			
				First Name Only If last name differs, please indicate in "other remarks" below.		Date of Birth	Student Rider (over age 19) Please check box below if full-time student.
ACTION CODE (Check One) (Changes must be made on the first of the month) Explain in "Other Remarks" if necessary.				Spouse		Children	
ADDITIONS: <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement							
TERMINATION: <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student							
STATUS CHANGE: <input type="checkbox"/> Individual to Family <input type="checkbox"/> Family to Individual <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____							
COBRA: <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____)				<input type="checkbox"/> Corrections / Other Remarks (Please Explain)			
Type of Coverage (Check One) <input type="checkbox"/> Individual <input type="checkbox"/> Family							
COORDINATION OF BENEFITS							
DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.							
Other Dental Insurance Name: _____						Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Other Dental Insurance Address: _____							
Employer Name Through Which You/Your Dependents Have Other Insurance: _____							
Group Policy No.		Policy Holder Name			Policy Holder ID No.		
MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.							
Name of Medical Insurance Company/HMO: _____						Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Name of Health Plan/Type of Coverage: _____							
Employer Name Through Which You/Your Dependents Have Other Insurance: _____							
Group Policy No.		Policy Holder Name			Policy Holder ID No.		

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____

Date _____

Benefits Administrator Authorization _____

Date _____