

Dental Benefits Enrollment/Coverage Status Form

PART A – Employee/Employer Information

Employee name (last, first, middle initial)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Married? <input type="checkbox"/> Y <input type="checkbox"/> N	Social Security Number ____ - ____ - _____	Date of Birth ____ / ____ / ____
Name of Employer	Employee's Work Site Location/Branch		Date of Hire ____ / ____ / ____	
Employee Position/Title	Do you have other dental benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of other plan, if applicable: _____	
Home mailing address (including City, State, ZIP Code)				<input type="checkbox"/> Check here if new address

PART B – Enrollment or Other Action Required

<input type="checkbox"/> Enroll in Dental Plan Enrollee Category <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA Network Selection, if applicable to your plan _____	<input type="checkbox"/> Waive Coverage—Please complete and sign Part F	<input type="checkbox"/> Cancel Employee Coverage (also cancels dependent coverage, if applicable) <input type="checkbox"/> Add Dependents (list new dependents to be covered in Part C) <input type="checkbox"/> Cancel Dependent Coverage <input type="checkbox"/> On all dependents currently enrolled <input type="checkbox"/> On dependent(s) listed here: _____
Coverage Effective/Change/Coverage Termination Date: _____ Reason for Action (at least one box must be checked; check all that apply):		
<input type="checkbox"/> New Hire	<input type="checkbox"/> Birth <input type="checkbox"/> Adoption Date: _____	<input type="checkbox"/> Death Date: _____
<input type="checkbox"/> Initial or Open Enrollment	<input type="checkbox"/> Termination of Employment Date: _____	<input type="checkbox"/> Change of Address
<input type="checkbox"/> Marriage Date: _____	<input type="checkbox"/> Loss of Eligibility due to: <input type="checkbox"/> Retirement <input type="checkbox"/> Age	<input type="checkbox"/> Other _____
<input type="checkbox"/> Divorce Date: _____	<input type="checkbox"/> Other _____	

PART C – Dependent Information – For Dependents to be Enrolled (For additional dependents, use a separate sheet and attach.)

Dependent to be enrolled (last, first, middle initial)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - _____	Date of Birth ____ / ____ / ____
	Relationship	Does he/she have other dental benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other plan, if applicable: _____
Dependent to be enrolled (last, first, middle initial)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - _____	Date of Birth ____ / ____ / ____
	Relationship	Does he/she have other dental benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other plan, if applicable: _____
Dependent to be enrolled (last, first, middle initial)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - _____	Date of Birth ____ / ____ / ____
	Relationship	Does he/she have other dental benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other plan, if applicable: _____
Dependent to be enrolled (last, first, middle initial)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - _____	Date of Birth ____ / ____ / ____
	Relationship	Does he/she have other dental benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other plan, if applicable: _____

PART D – Signature for Enrollment and Change of Status

If enrolled, I agree to make the required contribution as stated in the group contract and to repay promptly any benefit payments to which I or my dependents were not entitled. I certify that the information contained in this form is true and correct to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Signature _____ Date _____

PART E – For Delta Dental Use Only

Group Number _____ Effective Date of Enrollment and/or Change _____ Termination Date _____

Waiver of Coverage—Sign here only if you are waiving Delta Dental coverage.

I hereby decline coverage because: I have other dental coverage. If other coverage, who is your current carrier? _____
 Other Reason for Waiver: _____

I understand that future enrollment of myself or my dependent(s) is subject to the eligibility requirements of my employer's dental plan. Please check with your group administrator to see if your plan allows for a future open enrollment period.

Signature _____ Date _____