

## DENTAL ENROLLMENT/CHANGE FORM

|              |                            |
|--------------|----------------------------|
| Group Number | Effective Date<br>/ /      |
| Sublocation  | Full Time Hire Date<br>/ / |

Please print legibly.

|  |                    |            |         |        |
|--|--------------------|------------|---------|--------|
| Social Security Number<br>- -  | Last Name          | First      | Initial | Gender |
| Birthdate (MM/DD/YY)<br>/ /  | Street Address     | City       | State   | Zip    |
| Group Name   | Location of Branch | Occupation |         |        |
| Marital Status:    Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/><br>Is your spouse currently employed by this company?    Yes <input type="checkbox"/> No <input type="checkbox"/><br>Are you covered by another dental plan?    Yes <input type="checkbox"/> No <input type="checkbox"/><br>Is your spouse covered by another dental plan?    Yes <input type="checkbox"/> No <input type="checkbox"/><br>Do you have dependent children?    Yes <input type="checkbox"/> No <input type="checkbox"/> Are your dependents covered by another dental plan?    Yes <input type="checkbox"/> No <input type="checkbox"/> |                    |            |         |        |

| Dependent(s) Information   |        |           |                      |   |   |
|--|--------|-----------|----------------------|---|---|
| If enrolling one dependent, ALL must be enrolled.<br>(List any additional children on an additional form.) |        |           |                      |   |   |
| Add  | Delete | Name      | Birthdate (MM/DD/YY) | M | F |
|  |        | Spouse    | / /                  |   |   |
|  |        | Dependent | / /                  |   |   |
|  |        | Dependent | / /                  |   |   |
|  |        | Dependent | / /                  |   |   |
|  |        | Dependent | / /                  |   |   |
|  |        | Dependent | / /                  |   |   |
|  |        | Dependent | / /                  |   |   |
|  |        | Dependent | / /                  |   |   |

| Enrollee Status Selection       |                          |
|---------------------------------|--------------------------|
| <b>Check one below:</b>         |                          |
| New Hire                        | <input type="checkbox"/> |
| Open Enrollment                 | <input type="checkbox"/> |
| Terminate Coverage              | <input type="checkbox"/> |
| Transfer from DeltaCare         | <input type="checkbox"/> |
| <b>(Qualifying Events Only)</b> |                          |
| Add/Delete Dependent            | <input type="checkbox"/> |
| Spouse Employment Change        | <input type="checkbox"/> |
| Marital Change                  | <input type="checkbox"/> |
| COBRA                           | <input type="checkbox"/> |
| Other (list below)              | <input type="checkbox"/> |

### Status Change Information

Is this change a qualifying event?    No     Yes  - Please list qualifying event \_\_\_\_\_  
( See Evidence of Coverage for a list of qualifying events. )

Add the dependent(s) listed above - [Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_]

Delete the dependent(s) listed above - [Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_]

Terminate employee coverage effective \_\_\_\_/\_\_\_\_/\_\_\_\_

Name Change (From) \_\_\_\_\_ (To) \_\_\_\_\_

COBRA - [Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_]

Transfer from sub loc. # \_\_\_\_\_ to sub loc. # \_\_\_\_\_ - [Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_]

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

I decline coverage at this time.

*Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_