# ENROLLMENT/CHANGE FORM

Delta Dental Insurance Company

High Plan ________

Low Plan _______

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
deltadentalins.com

**VERY IMPORTANT — Please Print Legibly**

## FOR GROUP USE ONLY

| Group No. | Division | State |
|---|---|---|
| Effective Date / / | Hire Date / / | |
| Name of Employer | | |
| Location | Pay Code | Benefit Package |

## Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified
❑ Part-Time ❑ Salaried ❑ Classified
❑ Retired ❑ Member/Other ______________

## COBRA (if applicable)

❑ Termination
❑ Reduction in Hours
❑ Divorce/Legal Separation*
❑ Widowed/Surviving Dependent*
❑ Dependent Child No Longer Eligible*

Indicate qualifying date: ______/______/______

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided**.

## Enrollee/Change Information

❑ New Enrollment ❑ Marital Status Change ❑ Terminate Enrollee Coverage ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

❑ Add/Delete Dependent ❑ Address Change ❑ Other ________________

## Primary Enrollee Information

| Social Security Number | Enrollee ID Number (if applicable) | Date of Birth / / | Gender ❑ Non-binary ❑ Male ❑ Female | Marital Status ❑ Single ❑ Married |
|---|---|---|---|---|
| First Name | Last Name | | | Middle Initial |
| Mailing Address (Street) | City | | State | ZIP Code |
| Email Address (internal use only) | Phone Number ( ) - | | | Phone Type Cell ❑ Work ❑ Home ❑ |
| Name of Other Dental Carrier | Policy Holder Name (first/last) | | | Date of Birth / / |
| Effective Date of Other Policy / / | Policy Holder Street Address | City | State | ZIP Code |

## Dependent Information

| Relationship | Dependent First Name (Last only if different from enrollee) | Add / Term | Social Security Number | Date of Birth | Non binary/ Male / Female | Student / Disabled** | Name of School (overage student)** |
|---|---|---|---|---|---|---|---|
| Spouse | | ❑ ❑ | | / / | ❑ ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ ❑ | ❑ ❑ | |

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Signature of Enrollee ____________________________________ Date ______/______/______