

# ENROLLMENT/CHANGE OF STATUS/WAIVER FORM



PLEASE KEEP A COPY FOR YOUR FILES. Please note that completing this form does not guarantee coverage.

## ALL GROUPS MUST COMPLETE THIS SECTION Note: Incomplete forms will be returned.

Delta Dental Group Number \_\_\_\_\_ Sublocation Number \_\_\_\_\_  Salaried  Hourly

Effective Date \_\_\_\_\_ Date of Hire \_\_\_\_\_ OR Date of Rehire \_\_\_\_\_  Non-Union  Union

Name of Employer \_\_\_\_\_ Location/Department \_\_\_\_\_  Other \_\_\_\_\_

Group Contact \_\_\_\_\_

Group Contact Phone \_\_\_\_\_ Group Contact Email \_\_\_\_\_

## EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

**Please check one of the options below:**

**Yes, I want to enroll in the dental plan offered by Delta Dental of Illinois. (Please select a network below.)**

Delta Dental PPO/Delta Dental Premier If applicable:  High Option  Low Option

DeltaCare DHMO (please complete the section below)

Dentist Name \_\_\_\_\_ Address \_\_\_\_\_ Facility Code \_\_\_\_\_

DeltaCare DHMO Dentist Change (please complete the section below)

Dentist Name \_\_\_\_\_ Address \_\_\_\_\_ Facility Code \_\_\_\_\_

**No, I do not want to enroll in the dental plan offered by Delta Dental of Illinois. (If you are declining, please write your name below and sign at the bottom of this form.)**

Social Security Number \_\_\_\_\_ Employee's Name \_\_\_\_\_

Alternate ID # \_\_\_\_\_ # Hours Worked \_\_\_\_\_ Job Title \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Marital Status:  S  M  Other Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

## REASON FOR SUBMITTING THIS FORM

Initial or Open Enrollment  COBRA COBRA End Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Retiree

Reinstatement due to:  Rehire  Loss of Other Coverage  Other \_\_\_\_\_

Add Dependent (list below) due to:

Birth  Adoption  Marriage  Loss of Other Coverage  Legal Guardianship  Disabled Dependent

Military Dependent  Other \_\_\_\_\_ Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

Drop Dependent (list below) due to:

Age  Death  Divorce  Other Coverage Elsewhere Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

Termination of Employment Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Covered Under Spouse Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name Change (Former Name \_\_\_\_\_)  Address Change

## COVERAGE DESIRED

Employee Only  Employee & Spouse  Employee & One Child  Employee & Children  Entire Family

Is spouse covered under another dental plan?  Yes  No Other Carrier Name \_\_\_\_\_

Are dependents covered by spouse's plan?  Yes  No Spouse's Carrier \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

## PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/mm/yyyy)	SEX (M or F)
<input type="checkbox"/>	<input type="checkbox"/>	1. Spouse:			
<input type="checkbox"/>	<input type="checkbox"/>	2. Child:			
<input type="checkbox"/>	<input type="checkbox"/>	3.			
<input type="checkbox"/>	<input type="checkbox"/>	4.			
<input type="checkbox"/>	<input type="checkbox"/>	5.			

I agree to continue membership in this program until the next open enrollment period and authorize payroll deduction where applicable.

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