

Enrollment/Eligibility Update

Plan Type: (as established between Employer and Delta Dental)

- Delta Dental Premier® Voluntary Plan Achieve Plan
 Delta Dental PPO Exclusive Panel Option (EPO) Small Group Plan



New Enrollment Waive Coverage Change Coverage Active Retired COBRA

EMPLOYEE INFORMATION (please Print or Type all information requested)

Employer: _____ Group # _____ Subgroup# _____
 SSN#: _____ Date of Birth: _____ Date of Hire: _____ Effective Date: _____
 Last Name: _____ First Name: _____ M F
 Street Address: _____ City: _____ State: _____ Zip _____

CHANGE TO EXISTING ELIGIBILITY (Indicate Type of Update/Change Below)

Please provide **EFFECTIVE DATE OF CHANGE** : Month: Day: Year:

<input type="checkbox"/> Name Change (listed above) <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Reinstatement of coverage (see reverse side) <input type="checkbox"/> Address Change (listed above) <input type="checkbox"/> COBRA Election (show start date in line above) <input type="checkbox"/> Late Enrollment (if applicable) <input type="checkbox"/> Change of Family Status <input type="checkbox"/> Add <input type="checkbox"/> Delete Dependent(s) <input type="checkbox"/> Add* <input type="checkbox"/> Delete Full-time Student	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption* <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> No Longer Eligible <input type="checkbox"/> Part-time to Full-time <input type="checkbox"/> Retiree <input type="checkbox"/> Add Disabled Child* <input type="checkbox"/> Transfer to Group#/ Subgroup# _____	Other Reason for change: _____ _____ _____ Select Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee, Spouse and Child(ren)
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*Legal Documentation Must be submitted with enrollment form for change to take place.

PLEASE LIST ALL DEPENDENT(S) All Fields Required

Add	Delete	Last Name:	First Name:	SSN#	Date of Birth	M	F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>

If you have more dependents to list, please use an additional enrollment form.

I understand that the terms of the contract between Delta Dental and my company may not allow late enrollment for my dependents. The contract may allow late enrollment but may require waiting periods or additional limitations.

Signature of Employee Date

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

The Section below is for Delta Dental use only.

Group#	Effective Date:	Billing Code:

Delta Dental of Colorado
4582 S Ulster St Ste 800
Denver CO 80237-2567

Telephone: 303-741-9300 ext 3200
Toll Free: 800-233-0860
Fax: 303-773-3880

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department representative can help you.

Status Definitions

Status Definitions appear at the top of the enrollment form. Please check the appropriate box in each section:

New Enrollment: Check for first time enrollment for yourself or your dependents.

Waive Coverage: Check if you do not want to take the dental coverage. Please note that not all plans allow waiver of coverage and some may have penalties for late enrollment.

Change Coverage: If you are making changes to your existing enrollment information, please check this box and complete the appropriate information under Change to Current Eligibility.

Also complete the following:

Active: You are a current/active subscriber.

Retiree: You are retired and your group continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber, but you have continued self-paid coverage under COBRA.

Group Number/Subgroup Number

Please enter the Delta Dental group number for the program you are enrolling in. If your Employer uses subgroup numbers please include the appropriate subgroup number. If you are unsure of your Group and/or subgroup number please contact your Human Resource Department.

Employee Information

This section must be completed to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective date

The date that Delta Dental coverage takes effect for you and/or your dependents.

Change to Existing Enrollment Information

This section should only be completed if you are making changes to your existing enrollment information.

Reinstatement: Check for reinstatement coverage for yourself or your dependents. Please provide reason for reinstatement (divorce, loss of coverage, retired, etc) in the section titled "Other Reason for Change".

Cancel Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member. This is not the same as Termination of Employment.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section also should be completed when transferring to COBRA.

When reporting a change or correction, please include an effective date of change and clearly state the reason for the change.

List of Dependents

This section should be completed when (1) Enrolling dependents and/or (2) if you have checked Change To Existing Eligibility and are changing information that was previously submitted to Delta Dental. Please include both first and last names, date of birth, and social security numbers of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Definitions:

Spouse: Your legal spouse.

Child(ren): include unmarried child(ren), stepchild(ren), legally-adopted and court-ordered foster children who lives with the employee in a regular parent-child relationship and meets the age limits specified between your employer and Delta Dental.

Common Law: if you add a common law spouse and later cancel coverage for this individual, you will be required to pro-

vide legal documentation before another common law spouse can be added to the plan. List Common Law as spouse.

Domestic Partner: May not be included in all employer group contracts with Delta Dental. If your group offers this as a dependent option please list partner as a spouse and provide all information requested.

***Disabled or full-time student:** If you have a disabled child or full-time college student please provide supporting documentation.

* Please attach supporting documentation to the enrollment form and send to Delta Dental Membership Accounting. Please see below for mailing location and fax number.

Privacy Policy Statement

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Enrollment forms, changes and those items requiring supporting documentation may be sent Delta Dental Membership Accounting via mail or fax:

Delta Dental of Colorado

PO Box 5468

Denver, CO 80217-5468

Fax number: 303-773-3880

Membership Accounting Phone:

303-741-9300 ext 3200