DELTA DENTAL®

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Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

For Employer Use Only	
Effective Date / /	Group No. MS 16103
Full Time Hire Date / /	Sublocation

Please select: Division: **High** ❑ 00001 **or** **Low** ❑ 00002

Check One (**Enrollees can change plans only during open enrollment.)

- ❑ New Hire
- ❑ Open Enrollment
- ❑ Change Dental Plans**
- ❑ COBRA
- ❑ Add/Delete Dependent
- ❑ Terminate Employee Coverage
- ❑ Spouse Employment Change
- ❑ Marital Change
- ❑ Other _____

Indicate qualifying date: (Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce
- ❑ Widowed/Surviving Dependent
- ❑ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Social Security # ___ — ___ — ___ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Delta State University Location

Marital Status: Single ❑ Married ❑ Gender: Male ❑ Female ❑ Phone # ( ) —

Do you have dependent children? Yes ❑ No ❑ Are you or your dependents covered under another dental plan? Yes ❑ No ❑

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

	Add	Delete	Male	Female	Date of Birth (Month) (Day) (Year)
Spouse:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	

❑ 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 Enrollee _____ Date _____