ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

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

1. 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____ Phone __________________ Group Contact Email ___________________________

2. EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

☐ **Yes**, I want to enroll in the dental and/or vision benefit plan(s) offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

- ☐ Delta Dental PPO/Delta Dental Premier If applicable: ☐ High Option ☐ Low Option
- ☐ DeltaCare (please complete the section below)
  Dentist Name ____ Address ___________________________________ Facility Code _______
- ☐ DeltaCare Dentist Change (please complete the section below)
  Dentist Name ____ Address ___________________________________ Facility Code _______
- ☐ DeltaVision®

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

Social Security Number ______________________________ Employee's Name ____
First Name MI Last 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

3. 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

4. PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/dd/yyyy)	SEX (M or F)
☐	☐	1. Spouse:			
☐	☐	2. Child:			
☐	☐	3.			
☐	☐	4.			
☐	☐	5.			

5. DENTAL COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ 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 ____

6. VISION COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Entire Family

I am requesting the coverage(s) I have selected above for which I am eligible under the contract issued by Delta Dental of Illinois for dental coverage and/or by ProTec Insurance Company for vision coverage. I agree to continue membership in this program until the next open enrollment period. I certify that all the information stated on this form is complete and true to the best of my knowledge and Delta Dental of Illinois/ProTec Insurance Company believing it to be true shall rely and act upon it accordingly. I authorize my employer/group to deduct from my pay and remit any required contributions for the cost of the selected coverage. This authorization is to remain in effect until Delta Dental of Illinois/ProTec Insurance Company is notified in writing to the contrary.

Signature of Applicant ____ Date ________________________

*Please Note: DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 369-0384 • Email eligibility@deltadentalil.com