

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 _____ Hourly Salaried
Effective Date _____ Date of Hire _____ OR Date of Rehire _____ Union Non-Union
Name of Employer _____ Location/Department _____ Other _____
Group Contact _____ Phone _____ Email _____

ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS

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
 DeltaCare DHMO (If selecting DeltaCare DHMO, please complete the DeltaCare DHMO Facility Election section below.)
 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 _____
First Name MI Last Name
Mailing Address _____
Street City State Zip
Phone Number _____ Marital Status: S M Other Date of Birth ____/____/____ Male Female

REASON FOR SUBMITTING THIS FORM

Reinstatement Due to Qualifying Event? Yes No If yes, please describe _____
 Open Enrollment COBRA If COBRA, End Date ____/____/____
 New Employee Reinstatement Change If this is for a change, what is the reason? _____
 Address Change Termination (Reason: _____) Termination Date ____/____/____
 Add Dependent Coverage (List Dependents below)* (Reason: _____) Date of Event ____/____/____
 Drop Dependent Coverage (List Dependents below)* (Reason: _____) Date of Event ____/____/____
*If you are adding or dropping a dependent due to a qualifying event, please describe: _____
 Name Change (Former Name: _____)

DELTACARE DHMO FACILITY ELECTION

If DeltaCare DHMO enrollment: Dentist Name: _____ Address: _____ Facility Code: _____
 Dentist Change (DeltaCare DHMO only): Dentist Name: _____ Address: _____ Facility Code: _____

COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family
Effective Date: ____/____/____ Does spouse have a dental plan? Yes No Are dependents covered by spouse's plan? Yes No
Spouse's Employer: _____ Spouse's Carrier: _____

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (Month/Day/Year)	SEX (M or F)
		1. Spouse:			
		2. Child:			
		3.			
		4.			
		5.			

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

Signature of applicant: _____ Date: _____

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 964-2997 • Email eligibility@deltadentalil.com

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