

Please check the coverages that you are applying for below. Availability is based on your group's selected plan of insurance.

Type:	Applying For:	Waiving/Declining For:
<p><u>DENTAL COVERAGE</u> Provided by Delta Dental of Illinois</p> <p>Are you applying for DeltaCare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you changing your DeltaCare Dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children</p> <p>Does spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are dependents covered by spouse's plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Carrier: _____</p> <p>If DeltaCare: Dentist Name: _____</p> <p>Facility Code: _____ Address: _____</p>	<p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Above Dependents</p>
<p><u>VISION COVERAGE</u> Provided by TruAssure</p>	<p><input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children</p>	<p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Above Dependents</p>

I am requesting the coverage(s) I have selected above under the group policy(ies) issued by, or which may be issued by Delta Dental of Illinois or TruAssure Insurance Company. I agree to continue membership in the program(s) elected above until the next open enrollment period and authorize my employer to deduct any required contribution to pay for the coverage(s) from my earnings.

Applicant's Signature _____ Date _____