Dental Benefits Enrollment/Coverage Status Form

PART A – Employee/Employer Information

Employee name *(last, first, middle initial)*	Gender ☐M ☐F	Married? ☐Y ☐N	Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of Birth ___ ___/___ ___/___ ___ ___ ___
Name of Employer	Employee's Work Site Location/Branch			Date of Hire ___ ___/___ ___/___ ___ ___ ___
Employee Position/Title			Do you have other dental benefits? ☐ Yes ☐ No Name of other plan, if applicable: ____________	
Home mailing address *(including City, State, ZIP Code)*				☐ Check here if new address

PART B – Enrollment or Other Action Required

☐ **Enroll in Dental Plan**
Enrollee Category
☐ Active Employee
☐ Retiree
☐ COBRA
Network Selection, if applicable to your plan______________________

☐ **Waive Coverage—Please complete and sign Part F**

☐ **Cancel Employee Coverage** (also cancels dependent coverage, if applicable)
☐ **Add Dependents** (list new dependents to be covered in Part C)
☐ **Cancel Dependent Coverage**
☐ On all dependents currently enrolled
☐ On dependent(s) listed here:______________________

Coverage Effective/Change/Coverage Termination Date ________________. Reason for Action *(at least one box must be checked; check all that apply)*:

☐ New Hire
☐ Initial or Open Enrollment
☐ Marriage Date: ________________
☐ Divorce Date: ________________
☐ Birth ☐ Adoption Date: ________________
☐ Termination of Employment Date: ________________
☐ Loss of Eligibility due to: ☐ Retirement ☐ Age
☐ Other________________________________
☐ Death Date:____________
☐ Change of Address
☐ Other____________________
____

PART C – Dependent Information – For Dependents to be Enrolled *(For additional dependents, use a separate sheet and attach.)*

Dependent to be enrolled *(last, first, middle initial)*	Gender / Relationship	Social Security Number	Date of Birth
	Gender ☐ M ☐ F	___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? ☐ Yes ☐ No Name of other plan, if applicable: ____________	
Dependent to be enrolled *(last, first, middle initial)*	Gender ☐ M ☐ F	___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? ☐ Yes ☐ No Name of other plan, if applicable: ____________	
Dependent to be enrolled *(last, first, middle initial)*	Gender ☐ M ☐ F	___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? ☐ Yes ☐ No Name of other plan, if applicable: ____________	
Dependent to be enrolled *(last, first, middle initial)*	Gender ☐ M ☐ F	___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? ☐ Yes ☐ No Name of other plan, if applicable: ____________	

PART D – Signature for Enrollment and Change of Status

If enrolled, I agree to make the required contribution as stated in the group contract and to repay promptly any benefit payments to which I or my dependents were not entitled. I certify that the information contained in this form is true and correct to the best of my knowledge. **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.**

Signature______________________________________ Date______________________________

PART E – For Delta Dental Use Only

Group Number____________________ Effective Date of Enrollment and/or Change______________ Termination Date____________

Waiver of Coverage—Sign here only if you are waiving Delta Dental coverage.

I hereby decline coverage because:
☐ I have other dental coverage. If other coverage, who is you current carrier? ______________________
☐ Other Reason for Waiver:______________________________

I understand that future enrollment of myself or my dependent(s) is subject to the eligibility requirements of my employer's dental plan.
Please check with your group administrator to see if your plan allows for a future open enrollment period.

Signature______________________________________ Date______________________________