

Dental Enrollment Form

SECTION 1 -- EMPLOYEE INFORMATION (Please complete in full and print clearly.)

Employee Last Name		First	MI	Social Security #		
Street Address				Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	Zip Code		Date of Birth / /	Employee number	
Home Phone Number () -	Reason: <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Increase in hours <input type="checkbox"/> Return from leave			Job Title:	Effective Date:	

SECTION 2 -- DENTAL ENROLLMENT

DENTAL COVERAGE	I elect coverage for: <input type="checkbox"/> Single <input type="checkbox"/> Single +1 <input type="checkbox"/> Family
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Dependent Information: *(Please complete if you are enrolling dependents for coverage)*

Last Name <i>(If Different From Above)</i>	First Name	MI	Relationship	Date of birth	Sex	Social Security #
Spouse:			Spouse			
Dependent(s):						

Do all of the dependent(s) listed above reside at the same address as the applicant? yes no
 If NO, list dependent(s) name and address: _____

SECTION 3 – Coordination of Benefits

ADDITIONAL DENTAL COVERAGE INFORMATION:

Do you or any family members **included on this enrollment form** have other dental coverage **in addition to** this plan? No Yes
If yes: Single Coverage or Family Coverage, if family please list names of covered dependents: _____

If family coverage, are you the Primary insurer? No Yes *This is determined by which parent's birth month falls first in a calendar year.*

SECTION 4 -- SIGNATURE (Employee must sign and date)

I authorize the required deduction (if any) from my wages. I understand that medical, dental and FSA deductions are pre-tax and I acknowledge that my Social Security Benefits may be slightly reduced as a result of my election. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this Benefits Election Form, I authorize Delta Dental to share information about me with any provider, sponsoring employer, or other entity, where such information is reasonably necessary for administration. I understand that my election is irrevocable for the plan year, unless I experience a qualifying event & notify the plan in writing within 30 days of the date of the event.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN DENIAL OF CLAIM(S), CANCELLATION OF OR RECISSION OF COVERAGE.

EMPLOYEE SIGNATURE	DATE SIGNED	PLAN ADMINISTRATOR SIGNATURE	DATE SIGNED
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