ENROLLMENT/CHANGE/WAIVER FORM FOR DENTAL AND/OR VISION COVERAGE

DELTA DENTAL

EMPLOYER USE ONLY

DENTAL GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

VISION GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING OR TERMINATING COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH MO / DAY / YR	SEX ❑ F ❑ M
			— —	/ /	

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME AND LOCATION (CITY & STATE)	DATE OF HIRE MO / DAY / YR
	/ /

PLAN(S) YOU WISH TO ENROLL IN (NOTE: YOU MAY ENROLL DEPENDENTS ONLY IN PLANS THAT YOU ENROLL IN)

❑ **DENTAL** ❑ **VISION**

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED	LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP SON	RELATIONSHIP DAU.	DATE OF BIRTH MO	DAY	YR
❑ DENTAL ❑ VISION	SPOUSE							
❑ DENTAL ❑ VISION								
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❑ DENTAL ❑ VISION								

REASON FOR SUBMITTING THIS FORM

❑ NEW ENROLLEE ❑ REHIRE (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

DATE OCCURRED

- ❑ BIRTH/ADOPTION (Name: _____) _____
- ❑ MARRIAGE/ ❑ DIVORCE _____
- ❑ ADD/ ❑ DROP DEPENDENT (Name: _____) _____
- ❑ TERMINATION OF BENEFITS (Reason: _____) _____
- ❑ LOSS OF DENTAL BENEFITS _____
- ❑ NAME CHANGE (Former Name: _____) _____
- ❑ ADDRESS CHANGE _____
- ❑ GROUP TRANSFER (From _____ to _____) _____
- ❑ COBRA APPLICATION _____

WHAT TYPE OF DENTAL COVERAGE ARE YOU APPLYING FOR?

❑ EMPLOYEE ONLY ❑ EMPLOYEE & SPOUSE ❑ EMPLOYEE & ONE CHILD
❑ EMPLOYEE & CHILDREN ❑ ENTIRE FAMILY ❑ NONE (See Below)

WHAT TYPE OF VISION COVERAGE ARE YOU APPLYING FOR?

❑ EMPLOYEE ONLY ❑ EMPLOYEE & SPOUSE ❑ EMPLOYEE & ONE CHILD
❑ EMPLOYEE & CHILDREN ❑ ENTIRE FAMILY ❑ NONE (See Below)

YOUR MARITAL STATUS ❑ SINGLE ❑ MARRIED

IF YOU ARE NOT ACCEPTING DENTAL COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO

IF YOU ARE NOT ACCEPTING VISION COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER VISION PLAN? ❑ YES ❑ NO

❑ **Accept Coverage**

X _____ _____
SIGNATURE IS REQUIRED DATE

COMPLETE THIS SECTION **ONLY** IF YOU ARE **WAIVING** COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.

SOCIAL SECURITY NUMBER

EMPLOYER NAME AND LOCATION

❑ **Waive Dental**

PLEASE CHECK ONE:

- ❑ I HAVE DENTAL COVERAGE THROUGH MY SPOUSE
- ❑ I HAVE OTHER DENTAL COVERAGE
- ❑ I DO NOT HAVE OTHER DENTAL COVERAGE

❑ **Waive Vision**

PLEASE CHECK ONE:

- ❑ I HAVE VISION COVERAGE THROUGH MY SPOUSE
- ❑ I HAVE OTHER VISION COVERAGE
- ❑ I DO NOT HAVE OTHER VISION COVERAGE

X _____ _____
SIGNATURE IS REQUIRED DATE