

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

PLEASE KEEP A COPY FOR YOUR FILES. *Please note that completing this form does not guarantee coverage.*

1. ALL GROUPS MUST COMPLETE THIS SECTION Note: Incomplete forms will be returned.

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

2. EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

Yes, I want to enroll in the dental and/or vision benefit plan(s) offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)
 Delta Dental PPO/Delta Dental Premier If applicable: High Option Low Option
 DeltaCare DHMO (please complete the section below)
 Dentist Name _____ Address _____ Facility Code _____
 DeltaCare DHMO Dentist Change (please complete the section below)
 Dentist Name _____ Address _____ Facility Code _____
 DeltaVision®
 No, I do not want to enroll in the dental benefit plan.
 No, I do not want to enroll in the vision benefit plan. *(If you are declining, please write your name below and sign at the bottom of this form.)*
 Social Security Number _____ Employee's Name _____
 Alternate ID # _____ # Hours Worked _____ Job Title _____
 Mailing Address _____
 Email Address _____ Phone Number _____
 Marital Status: S M Other Date of Birth ____/____/____ Male Female

3. REASON FOR SUBMITTING THIS FORM

Initial or Open Enrollment COBRA COBRA End Date ____/____/____ Retiree
 Reinstatement due to: Rehire Loss of Other Coverage Other _____
 Add Dependent (list below) due to:
 Birth Adoption Marriage Loss of Other Coverage Legal Guardianship Disabled Dependent
 Military Dependent Other _____ Date of Qualifying Event ____/____/____
 Drop Dependent (list below) due to:
 Age Death Divorce Other Coverage Elsewhere Date of Qualifying Event ____/____/____
 Termination of Employment Date ____/____/____ Covered Under Spouse Date ____/____/____
 Name Change (Former Name _____) Address Change

4. PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/dd/yyyy)	SEX (M or F)
<input type="checkbox"/>	<input type="checkbox"/>	1. Spouse:			
<input type="checkbox"/>	<input type="checkbox"/>	2. Child:			
<input type="checkbox"/>	<input type="checkbox"/>	3.			
<input type="checkbox"/>	<input type="checkbox"/>	4.			
<input type="checkbox"/>	<input type="checkbox"/>	5.			

5. DENTAL COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family
 Is spouse covered under another dental plan? Yes No Other Carrier Name _____
 Are dependents covered by spouse's plan? Yes No Spouse's Carrier _____
 Spouse's Employer _____

6. VISION COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family

I am requesting the coverage(s) I have selected above for which I am eligible under the contract issued by Delta Dental of Illinois for dental coverage and/or for vision coverage. I agree to continue membership in this program until the next open enrollment period. I certify that all the information stated on this form is complete and true to the best of my knowledge and Delta Dental of Illinois Insurance Company believing it to be true shall rely and act upon it accordingly. I authorize my employer/group to deduct from my pay and remit any required contributions for the cost of the selected coverage. This authorization is to remain in effect until Delta Dental of Illinois Insurance Company is notified in writing to the contrary.

Signature of Applicant _____ Date _____