DELTA DENTAL®

Benefits Enrollment / Change Application

☐ Dental ☐ Vision ☐ Both

Please send completed, signed application to:
E-mail – GAService@deltadentalmo.com
Mail – 12399 Gravois Road
St. Louis, MO 63127

☐ New applicant for coverage complete sections 1, 2, 3, and 5.
☐ Change/Subscriber Authorization Form - complete all applicable sections.
☐ I do not wish to enroll. (Declination of coverage must be accompanied by the employee's signature on the other side of this page.

SECTION 1 – EMPLOYEE INFORMATION

Group Name	**Group # / Sublocation #** Dental: Vision:	**Division/Store Location**	**If applicable:** Dental: ☐ High Option ☐ Low Option Vision: ☐ High Option ☐ Low Option
Employee Last Name		**First Name**	

Social Security Number	**Date of Birth** (mm/dd/yyyy) ____ / ____ / _____	**Coverage Effective Date (**mm/dd/yyyy) ____ / ____ / _____	**Employee Hire Date** (mm/dd/yyyy) ____ / ____ / _____

Street Address ☐ Check here if new address

City	**State**	**Zip Code**

SECTION 2 – SPOUSE AND DEPENDENT INFORMATION

Please complete for spouse/dependents to be enrolled or cancelled. Use a second form for additional dependents if needed.
Important: For court-ordered dependents, legal documentation must be attached.

Level of Coverage:
☐ **Dental**: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Family ☐ Waive Coverage
☐ **Vision**: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Family ☐ Waive Coverage

Vision Plan	**Dental Plan**	Name:	**Relationship**	**Date of Birth** (mm/dd/yyyy)
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel		Spouse *	
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel		Dependent	
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel		Dependent	
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel		Dependent	
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel		Dependent	
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel		Dependent	

***or Domestic Partner if covered by your plan.**

Continued on next page.

SECTION 3 – COORDINATION OF BENEFITS

Dental Coverage:

A. Does your spouse have other group coverage? ☐ Yes ☐ No
B. If yes to A, will you continue on your spouse's plan? ☐ Yes ☐ No
C. If yes to A, will your dependents continue on your spouse's plan? ☐ Yes ☐ No
D. If yes to A, is the coverage through a retiree plan? ☐ Yes ☐ No
E. If yes to B or C, provide the name and effective date of your spouse's coverage.
_____
F. If yes to B or C, please provide your spouse's date of birth: _____
G. If your dependents are covered by a dental plan other than your spouse's, list the policyholder's name and the carrier:
_____

SECTION 4 - CHANGE OF COVERAGE INFORMATION

Coverage change:

☐ **Dental**: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Family ☐ Waive Coverage
☐ **Vision**: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Family ☐ Waive Coverage

Name change: From: Last Name: _____ First Name: _____
To: Last Name: _____ First Name: _____

Reason for change *(All changes must be made within 31 days of the qualifying event)*

Additions:
Effective date of addition: ___ / ___ / _____
☐ Birth
☐ Marriage
☐ Adoption
☐ Court-ordered dependent (attach legal documentation)
☐ Open enrollment
☐ Other (describe) _____

Cancellations:
Effective date of cancellation: ___ / ___ / _____
☐ Death
☐ Employee terminated on ___ / ___ / _____
☐ Divorce
☐ Retired
☐ Other (describe) _____

SECTION 5 - EMPLOYEE AUTHORIZATION

I represent that the information I have provided on this form is complete and accurate. I request the group coverage to which I am entitled, or may become entitled, under my group's contract. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I understand that courses of dental or vision treatment which began before my effective date may not be covered. I understand that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract and/or Membership Certificate/Master Policy.

_____ ____ / ____ / _____
Employee Signature Date

No action requested can be taken without your signature above.