

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM



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

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 _____
Group Contact Phone _____ Group Contact Email _____

EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

Yes, I want to enroll in the dental plan offered by Delta Dental of Illinois. (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 _____

No, I do not want to enroll in the dental plan offered by Delta Dental of Illinois. (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 _____ First Name MI Last Name
Mailing Address _____ Street City State Zip
Email Address _____ Phone Number _____
Marital Status: S M Other Date of Birth ____/____/____ Male Female

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

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 _____

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/mm/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.			

I agree to continue membership in this program until the next open enrollment period and authorize payroll deduction where applicable.

Signature of Applicant _____

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 369-0384 • Email eligibility@deltadentalil.com

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