**DELTA DENTAL**
Delta Dental Insurance Company
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1-800-521-2651
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Delta Dental Insurance Company

# ENROLLMENT/CHANGE FORM

| For Employer Use Only | |
|---|---|
| Effective Date 1 / 1 / 2010 | Group No. |
| Full Time Hire Date / / | Sublocation |

## Check One (**Enrollees can change plans only during open enrollment.)

- ☐ New Hire
- ☑ Open Enrollment
- ☐ Change Dental Plans**
- ☐ COBRA
- ☐ Add/Delete Dependent
- ☐ Terminate Employee Coverage
- ☐ Spouse Employment Change
- ☐ Marital Change
- ☐ Other _____

Indicate qualifying date: 01 (Month) 01 (Day) 2010 (Year)

## COBRA Enrollment Only

Please indicate qualifying event:

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Widowed/Surviving Dependent
- ☐ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

## Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Social Security # — — Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Location

Marital Status: Single ☐ Married ☐ Gender: Male ☐ Female ☐ Phone # ( ) —

Do you have dependent children? Yes ☐ No ☐ Are you or your dependents covered under another dental plan? Yes ☐ No ☐

## Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

| | Add | Delete | Male | Female | Date of Birth (Month) (Day) (Year) |
|---|---|---|---|---|---|
| Spouse: | ☐ | ☐ | ☐ | ☐ | |
| Dependent: | ☐ | ☐ | ☐ | ☐ | |
| Dependent: | ☐ | ☐ | ☐ | ☐ | |
| Dependent: | ☐ | ☐ | ☐ | ☐ | |
| Dependent: | ☐ | ☐ | ☐ | ☐ | |
| Dependent: | ☐ | ☐ | ☐ | ☐ | |
| Dependent: | ☐ | ☐ | ☐ | ☐ | |
| Dependent: | ☐ | ☐ | ☐ | ☐ | |

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

☐ I decline coverage at this time.

*Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

Signature of Enrollee _____ Date _____

Form 3400 (Rev. 2-02)

Original