



Delta Dental Insurance Company
ENROLLMENT/CHANGE FORM

P.O. Box 1809
 Alpharetta, GA 30023-1809
 1-800-521-2651
 Fax: 770-641-5393

For Employer Use Only	
Effective Date / /	Group No. MS 10050
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:

_____/_____/_____
 (Month) (Day) (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)

Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: _____
(Month) (Day) (Year)

Name of Employer/Group MS Conference of the UMC 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:			
Spouse: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			

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 _____