DELTA DENTAL®

ENROLLMENT/CHANGE FORM

Delta Dental

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055-6999
deltadentalins.com

VERY IMPORTANT — Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
01261	01999	DE

Effective Date / / | Hire Date / /

Name of Employer: State of Delaware

Location | Pay Code | Benefit Package

Enrollee/Change Information

❑ New Enrollment ❑ Marital Status Change ❑ Terminate Enrollee Coverage ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

❑ Add/Delete Dependent ❑ Address Change ❑ Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Non-binary ❑ Male ❑ Female	❑ Single ❑ Married

First Name | Last Name | Middle Initial

Mailing Address (Street) | City | State | ZIP Code

Email Address (internal use only) | Phone Number ( ) - | Phone Type Cell ❑ Work ❑ Home ❑

Name of Other Dental Carrier | Policy Holder Name (first/last) | Date of Birth / /

Effective Date of Other Policy / / | Policy Holder Street Address | City | State | ZIP Code

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified
❑ Part-Time ❑ Salaried ❑ Classified
❑ Retired ❑ Member/Other _____

COBRA (if applicable)

❑ Termination
❑ Reduction in Hours
❑ Divorce/Legal Separation*
❑ Widowed/Surviving Dependent*
❑ Dependent Child No Longer Eligible*

Indicate qualifying date: ____/____/____

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided**.

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Non binary/ Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Enrollee _____ Date ____/____/____