LTD

State of Delaware
Office of Pensions

Dental Application or Refusal

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Effective Date: ________________

A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:

New Enrollment	Termination/Refusal	Change of Dependents
Coverage Change	Address Change	☐ Name Change

B. PLEASE SELECT COVERAGE OPTION:

Individual	Individual & Child(ren)
Individual & Spouse	Family

C. PLEASE SELECT ONE DENTAL PLAN:

Delta Dental
Dominion National *Must provide Dentist Name

D. PLEASE COMPLETE ALL PERSONAL INFORMATION:

Pension ID or SSN:	Name (Last):	Name (First):	Date of Birth:
Address:			Home Phone Number:
City:	State:	Zip Code:	Work Phone Number:

E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

Last Name	First Name	Date of Birth	Social Security Number	* Primary Care Dentist Name or Code
Self				
Spouse				
Child fulltime student disabled				
Child fulltime student disabled				
Child fulltime student disabled				

The dental plan is a **binding election**. Once enrolled, you may not drop coverage during the plan year unless you experience a qualifying event. **Please note:** ***The enrollment form is for the Pension Office's use only and will not be used for any external purpose.***

X________________________________ X________________________________

SIGNATURE **DATE**