Applicant: select an insurance plan, or Patient Direct discount plan below.	❑ Delta Dental Premier® ❑ Exclusive Panel Option (EPO)	❑ Delta Dental PPO℠
❑ Delta Dental Patient Direct® (for Patient Direct, the following fields are mandatory):		
1. Patient Direct Provider Name: ______	2. Patient Direct Provider Number: ______	

❑ New Enrollment ❑ Waive Coverage ❑ Change Coverage | ❑ Active ❑ Retired ❑ COBRA/State Continuation

Employee Information (please print or type)

Employer:	Group #:	Subgroup #:	
SSN:	Date of Birth:	Date of Hire:	Effective Date:
Last Name:	First Name:	M / F	
Street Address:	City:	State:	Zip:
E-mail Address:			

Your e-mail address will not be used for any purpose other than communications from Delta Dental of Colorado.

Indicate changes to existing eligibility below

Date change is effective: (mm/dd/yyyy):

Reason for change/explanation:

- ❑ Name Change (list above)
- ❑ Cancel Coverage
- ❑ Employment Terminated
- ❑ Reinstatement of Coverage (see reverse)
- ❑ Address Change (list above)
- ❑ COBRA/State Continuation (list start date above)
- ❑ Late Enrollment (if applicable)
- ❑ Family Status Change
  - ❑ Add Dependent ❑ Delete Dependent
  - ❑ Add FT Student* ❑ Delete FT Student

List effective date for checked boxes below.

- ❑ Marriage Date: ______
- ❑ Birth / Adoption* Date: ______
- ❑ Divorce Date: ______
- ❑ Death Date: ______
- ❑ No Longer Eligible Date: ______
- ❑ Part-time to Full-time Date: ______
- ❑ Retiree Date: ______
- ❑ Add Disabled Child* Date: ______
- ❑ Transfer to group/subgroup: ______ Date: ______

Other reason for change:

Select Coverage:

❑ Employee Only ❑ Employee and Spouse

❑ Employee and Children ❑ Employee, Spouse and Children

Please list all dependents. All fields are required.

Add	Delete	Last Name	First Name	SSN	Date of Birth	M	F
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑

If you need more space to list additional dependents, please use a second enrollment form.

I understand that the terms of the contract between Delta Dental and my company may not allow for late enrollment for my dependents. The contract may allow for late enrollments, but may require waiting periods or additional limitations.

Employee's Signature Date

It is unlawful to knowingly provide false, incomplete or misleading information to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance and civic damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

Delta Dental of Colorado
PO Box 5468
Denver, CO 80217-5468

Phone: 303-741-9300 ext. 3200
Toll-free: 800-233-0860 ext. 3200
Fax: 303-773-3880

For Delta Dental internal use only.		
Group #:	Effective Date:	Billing Code:

DELTA DENTAL

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department representative can help you.

Status Definitions

Status Definitions appear at the top of the enrollment form. Please check the appropriate box in each section:

New Enrollment: Check for first time enrollment for yourself or your dependents.

Waive Coverage: Check if you do not want to take the dental coverage. Please note that not all plans allow waiver of coverage and some may have penalties for late enrollment.

Change Coverage: If you are making changes to your existing enrollment information, please check this box and complete the appropriate information under Change to Current Eligibility.

Also complete the following:

Active: You are a current/active subscriber.

Retiree: You are retired and your group continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber, but you have continued self-paid coverage under COBRA.

Group Number/Subgroup Number

Please enter the Delta Dental group number for the program you are enrolling in. If your Employer uses subgroup numbers please include the appropriate subgroup number. If you are unsure of your Group and/or subgroup number please contact your Human Resource Department.

Employee Information

This section must be completed to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective date

The date that Delta Dental coverage takes effect for you and/or your dependents.

Change to Existing Enrollment Information

This section should only be completed if you are making changes to your existing enrollment information.

Reinstatement: Check for reinstatement coverage for yourself or your dependents. Please provide reason for reinstatement (divorce, loss of coverage, retired, etc) in the section titled "Other Reason for Change".

Cancel Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member. This is not the same as Termination of Employment.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section also should be completed when transferring to COBRA.

When reporting a change or correction, please include an effective date of change and clearly state the reason for the change.

List of Dependents

This section should be completed when (1) Enrolling dependents and/or (2) if you have checked Change To Existing Eligibility and are changing information that was previously submitted to Delta Dental. Please include both first and last names, date of birth, and social security numbers of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Definitions:

Spouse: Your legal spouse.

Child(ren): include unmarried child(ren), stepchild(ren), legally-adopted and court-ordered foster children who lives with the employee in a regular parent-child relationship and meets the age limits specified between your employer and Delta Dental.

Common Law: if you add a common law spouse and later cancel coverage for this individual, you will be required to provide legal documentation before another common law spouse can be added to the plan. List Common Law as spouse.

Domestic Partner: May not be included in all employer group contracts with Delta Dental. If your group offers this as a dependent option please list partner as a spouse and provide all information requested.

* **Disabled or full-time student:** If you have a disabled child or full-time college student please provide supporting documentation.

* Please attach supporting documentation to the enrollment form and send to Delta Dental Membership Accounting. Please see below for mailing location and fax number.

Privacy Policy Statement

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

Enrollment forms, changes and those items requiring supporting documentation may be sent Delta Dental Membership Accounting via mail or fax:

Delta Dental of Colorado
PO Box 5468
Denver, CO 80217-5468

Fax number: 303-773-3880

Membership Accounting Phone:
303-741-9300 ext 3200