

Employer Group Name		Delta Dental Group Number		Date of Hire	Location No. (if applicable)
Social Security No. / Subscriber I.D. No.		Subscriber Name: First - Last			
Date of Birth - MM/DD/YYYY		Street Address / P.O. Box No.			
Effective Date of Action:	Apt. No.	City	State	Zip	

**QUALIFYING EVENT**

Open Enrollment       Workers' Compensation  
 New Hire/Re-hire     Return From Leave of Absence  
 Marriage                 Dependent's Loss of Coverage  
 Divorce                 Full-Time/Part-Time Status  
 Birth or Adoption      Death of a Member

**DEPENDENT INFORMATION**

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship

**ACTION CODE** (Check one. Changes must be made on the first of the month.)

**ADDITIONS:**

New Subscriber  
 Add Dependent to Family  
 Reinstatement

**TERMINATION:**

Remove Subscriber  
 Remove Dependent / Student (List dependent name.)

**STATUS CHANGE:**

Change "Type of Coverage"  
 Please indicate change (e.g. Individual to Family) in the section below.  
 Name / Address Change  
 Transfer from Sublocation # \_\_\_\_\_ to # \_\_\_\_\_

**CORRECTIONS / OTHER REMARKS**

**COBRA:**

Reinstatement of Subscriber  
 Addition of Dependent — (From prior ID # \_\_\_\_\_ )

**TYPE OF COVERAGE** (Check one)

Individual     Individual & Spouse     Individual & Child(ren)     Family

**COORDINATION OF BENEFITS**

**DENTAL** — Are You or Any of Your Dependents Covered by Another Dental Plan?     No     Yes    If Yes, Please Complete the Section Below.

Other Dental Insurance Name: \_\_\_\_\_ Type of Coverage:  Individual     Family

Other Dental Insurance Address: \_\_\_\_\_

Employer Name Through Which You/Your Dependents Have Other Insurance: \_\_\_\_\_

Group Policy No.	Policyholder Name	Policyholder ID No.
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**MEDICAL** — Are You or Any of Your Dependents Covered by A Medical Plan?     No     Yes    If Yes, Please Complete the Section Below.

Name of Medical Insurance Company/HMO: \_\_\_\_\_ Type of Coverage:  Individual     Family

Name of Health Plan/Type of Coverage: \_\_\_\_\_

Employer Name Through Which You/Your Dependents Have Other Insurance: \_\_\_\_\_

Group Policy No.	Policyholder Name	Policyholder ID No.
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*I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.*

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Benefits Administrator Authorization \_\_\_\_\_ Date \_\_\_\_\_



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Other Dental Insurance Name: \_\_\_\_\_      Type of Coverage:     Individual     Family

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