



Delta Dental Plan of Colorado

PO Box 5468

Denver, Colorado 80217-5468

(303) 741-9300 (800) 233-0860 (Toll Free)

(303) 773-3880 (FAX)

www.deltadentalco.com

ENROLLMENT and STATUS CHANGE FORM

Please Print or TYPE

Be sure form is completed in full for proper enrollment

EMPLOYEE INFORMATION				
1. GROUP NAME:		2. GROUP NUMBER:	3. DATE OF HIRE:	4. EFFECTIVE DATE:
5. SOC. SEC. NO.:	6. DATE OF BIRTH:	7. LAST NAME (Subscriber):		8. FIRST NAME:
- -	/ /			
9. HOME ADDRESS:		10. CITY:	11. STATE:	12. ZIP:

PLAN SELECTION
13. PLAN: Select plan you are enrolling in OR plan you are currently enrolled in: <input type="checkbox"/> DeltaPremier <input type="checkbox"/> DeltaPreferred Option (DPO) <input type="checkbox"/> Exclusive Panel Option (EPO) <input type="checkbox"/> DeltaCare *If selected, each subscriber & dependent must choose a DeltaCare Dentist.

REASON FOR SUBMISSION (CHECK ONE)	
14. Requested: <input type="checkbox"/> New Enrollment <input type="checkbox"/> CHANGE Family Status { } Add Dependent(s) { } Delete Dependent(s) <input type="checkbox"/> CHANGE Name from _____ to _____ <input type="checkbox"/> Return from leave DATE: _____ <input type="checkbox"/> SWITCH my coverage to: { } DeltaPremier { } DeltaPreferred Option (DPO) { } Exclusive Panel Option (EPO) { } DeltaCare	15. Reason for Change: Date of Event <input type="checkbox"/> Marriage ___/___/___ <input type="checkbox"/> Birth / Adoption ___/___/___ <input type="checkbox"/> Divorce ___/___/___ <input type="checkbox"/> Legal Separation ___/___/___ <input type="checkbox"/> Death ___/___/___ <input type="checkbox"/> Employment Terminated ___/___/___ <input type="checkbox"/> No Longer Eligible ___/___/___ <input type="checkbox"/> Spouse Lost Coverage ___/___/___ <input type="checkbox"/> Other: _____ ___/___/___ 16. Select Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Children <input type="checkbox"/> Employee and Child <input type="checkbox"/> Employee, Spouse and Children

PLEASE LIST ALL DEPENDENT(S) TO BE COVERED							
17.		18. Last Name	19. First Name	20. Social Security #	21. Date of Birth	22. Sex: M or F	*DeltaCare enrollment ONLY:
ADD	DELETE	(include if different)		Required			23. Dentist & Provider #
<input type="checkbox"/>	<input type="checkbox"/>	Subscriber		/ /			#
<input type="checkbox"/>	<input type="checkbox"/>	Spouse		/ /			#
<input type="checkbox"/>	<input type="checkbox"/>	Child		/ /			#
<input type="checkbox"/>	<input type="checkbox"/>	2.		/ /			#
<input type="checkbox"/>	<input type="checkbox"/>	3.		/ /			#
<input type="checkbox"/>	<input type="checkbox"/>	4.		/ /			#

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

I authorize payroll deduction, if applicable.

24. Signature of Employee _____

Date _____

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan 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 participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

For DDPC Use ONLY

Group #	Eff. Date	Billing Code	Subgroup #
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