DELTA DENTAL®

Employee Enrollment Form

IMPORTANT: Enrollment forms with incomplete or missing information will be returned.

This Section to Be Completed By the Group Administrator

Account Name:		Effective Date:
Account No:	Sub-Account No:	Sub-Sub Account No:
Department:		Benefit Plan (Ex: Low or High):

Employment Status (choose one):
❑ Active ❑ COBRA ❑ Continuation ❑ Disability/LTD
❑ Leave of Absence ❑ Retiree ❑ Retiree-Early ❑ Surviving Dependent

Employee Type (choose one):
❑ Hourly ❑ Salaried ❑ Full-Time ❑ Part-Time
❑ Temporary ❑ Reduced Schedule ❑ Salaried Non-Exempt

Section A: Enrollment/Change

❑ New Hire ❑ Open Enrollment ❑ Reinstatement ❑ Cancel Coverage ❑ COBRA (Effective Date _____/_____/_____/)

Qualifying Event: ❑ Add dependent, spouse, or domestic partner ❑ Drop dependent, spouse, or domestic partner
Reason(s) For Qualifying Event: ❑ Marriage ❑ Loss of other group coverage ❑ Divorce ❑ No longer a dependent ❑ Birth or adoption
❑ Death of spouse/dependent ❑ Other_____

❑ Previous Name_____ ❑ Address ❑ Telephone ❑ Other_____

❑ Decline Coverage - **I understand that I have been offered and have elected to decline coverage under my employer sponsored dental plan with Delta Dental at this time. I will not be eligible to enroll until the next open enrollment period or in the event of a qualifying event.**

(Sign, date, and complete the first line of section B.) Signature:_____ Date:_____

Section B: Employee Information

Last Name:	First Name:	MI:	Social Security Number: _____-_____-_____
Mailing Address:	City:	State:	Zip:
Home Telephone:	Date of Birth: _____/_____/_____	Gender: ❑ Male ❑ Female ❑ Unspecified	
Marital Status: ❑ Single ❑ Married	Date of Hire: _____/_____/_____	Group Assigned ID (if applicable):_____	
Email Address:		Cell Phone:	

Would you like to receive communications from Delta Dental of Colorado by email and text message? ❑ Yes ❑ No
Your email address and cell phone will not be used for any purpose other than communications from Delta Dental of Colorado.

Section C: Coverage

Dental (check one): ❑ Delta Dental Premier® ❑ Delta Dental PPO™
❑ Delta Dental PPO plus Premier™ ❑ Exclusive Panel Option (EPO)
❑ Delta Dental MAC PPO™ ❑ Delta Dental PPO™ Reimbursement
❑ Delta Dental Patient Direct® (complete required section below)

DeltaVision® (check one, if applicable):
❑ DeltaVision 150 Plan
❑ DeltaVision 175 Plan
❑ DeltaVision 175 + EasyOptions Plan

Patient Direct Provider Name:

Provider Practice Name: Office ID:

Coverage Type | Dental (check one):
❑ Employee ❑ Employee + Child ❑ Employee + Children ❑ Employee + Spouse (Domestic Partner/Common Law/Civil Union)
❑ Employee + Family

Coverage Type | Vision (check one):
❑ Employee ❑ Employee + Child ❑ Employee + Children ❑ Employee + Spouse (Domestic Partner/Common Law/Civil Union)
❑ Employee + Family

Please return this completed form as part of the New Group Application and Enrollment Packet to salesteam@ddpco.com. See the cover sheet for all the required forms.

Delta Dental of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

Section D: List All Members to Be Enrolled/Dropped Based on the Coverage Type Selected:
Dental Coverage

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F/U)	Date of Birth (MM/DD/YYYY)
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						

Section D: List All Members to Be Enrolled/Dropped Based on the Coverage Type Selected:
DeltaVision® Coverage

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F/U)	Date of Birth (MM/DD/YYYY)
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						

Section D: List All Members to Be Enrolled/Dropped Based on the Coverage Type Selected:
Delta Dental Patient Direct® Coverage

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F/U)	Date of Birth (MM/DD/YYYY)
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						

Section E: Authorization and Certification

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 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.

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 near the top of the enrollment form. Please check the appropriate box in each section.

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

Waive Coverage: Check if you do not want to take dental coverage. Please note that not all plans allow waiving of coverage.

Change Coverage: If you are making changes to your existing enrollment information, please check this box and complete the appropriate information under Changes to Existing Eligibility near the bottom of the form.

Also complete the following:

Active: You are a current employee.

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

COBRA: You are no longer an active employee, 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 resources 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.

List of Dependents
This section should be completed when:
1.) Enrolling dependents and/or
2.) You have checked Change Coverage 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 for any individuals for whom you are enrolling or submitting a change or correction.

Standard Dependent Definitions (May Vary)

Spouse: Your legal spouse.

Child(ren): Includes unmarried and married child(ren), step-child(ren), legally adopted child(ren), and court-ordered foster child(ren) in a parent/child relationship who meet 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 can be added to the plan. List Common Law as spouse.

Civil Union: Civil Union is included in all fully insured employer group contracts with Delta Dental. Fully insured groups offer this as a dependent option; therefore, please list partner as a spouse and provide all information requested.

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 a full-time college student, please provide supporting documentation.

Changes to Existing Eligibility Information
This section should be completed only 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, etc.) under 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 Employment Termination.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also 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. Please attach supporting documentation to the enrollment form and submit to your HR office.

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 should be submitted to your human resources department office so they can make changes to your plan through Delta Dental of Colorado's employer portal.