DELTA DENTAL

Enrollment Form

Applicant: Select an insurance plan or Patient Direct discount plan (below).

❑ Delta Dental Premier® ❑ Delta Dental PPO℠ ❑ Delta Dental PPO℠ Plus Premier
❑ Exclusive Panel Option (EPO) ❑ Delta Dental MAC 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 clearly or type). All fields are required.

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

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.

Changes to Existing Eligibility

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
- ❑ Other Reason for Change: ______________________

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: ______________

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.

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

Phone: 303-741-9300, ext. 3900