

Please print.

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	
<b>QUALIFYING EVENT</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> New Hire/Re-hire <input type="checkbox"/> Return From Leave of Absence <input type="checkbox"/> Marriage <input type="checkbox"/> Dependent's Loss of Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Death of a Member			<b>DEPENDENT INFORMATION</b>		
			<b>First Name Only</b> If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship
<b>ACTION CODE</b> (Check one. Changes must be made on the first of the month.)					
<b>ADDITIONS:</b> <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement					
<b>TERMINATION:</b> <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student (List dependent name.)					
<b>STATUS CHANGE:</b> <input type="checkbox"/> Individual to Family <input type="checkbox"/> Family to Individual <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____			<b>CORRECTIONS / OTHER REMARKS</b> _____ _____ _____		
<b>COBRA:</b> <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____ )					
			<b>TYPE OF COVERAGE</b> (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> 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 \_\_\_\_\_