

Enrollment/Change Form

Check One:

- New Application for Coverage
- Change Authorization
- Waiver of Coverage (complete Section (6) ONLY)

Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)

Add <input type="checkbox"/>	Social Security / ID Number:	Group Number:	Employer/Group Name: (Please do not abbreviate)		
Terminate <input type="checkbox"/>					
Employee Name: (First, Middle Initial, Last)					Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Address:		City:	State:	Zip Code:	Birth Date: (mm/dd/yy)
Single <input type="checkbox"/>		Effective Date: (mm/dd/yy)	Type of Medical Coverage:		Medical Carrier and Address:
Married <input type="checkbox"/>			Single <input type="checkbox"/>	Family <input type="checkbox"/>	

Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)

Action:	Effective Date:	Spouse Name: (First, Middle Initial, Last)			Birth Date:
Add <input type="checkbox"/>	(mm/dd/yy)		Male	<input type="checkbox"/>	
Terminate <input type="checkbox"/>			Female	<input type="checkbox"/>	

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:

Action:	Effective Date:	Dependent Name: (First, Middle Initial) (Last Name, if different)	Male	Female	Birth Date:
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					

Section 3 OTHER INSURANCE INFORMATION: (Complete ONLY if requesting coverage for dependent[s])

	Spouse	Children	
Are your dependents covered by another <u>dental</u> plan?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Dental Carrier:
Are your dependents covered by another <u>medical</u> plan?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Address:
If YES, please provide spouse's Social Security #: _____			Medical Carrier:
Spouse's employer: _____			Address:

Section 4 CHANGES: (Please mark all appropriate boxes that apply to change[s] you wish to make)

DELTA DENTAL OF KANSAS MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT

DATE OF EVENT: _____

Name Change: From: _____ To: _____

Marriage Divorce Other: _____ Adoption/Legal Custody of Child

Section 5 SIGNATURE / AUTHORIZATION:

I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.

Authorization/Signature for Enrollment/Change[s]: _____ Date: _____

Section 6 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)

This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer, and I have decided that I:

- Do not** want dental coverage for myself because: _____.
- Do not** want dental coverage for my spouse and/or my children.

I understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage: _____ Date: _____

Printed-Employee Name: (First, Middle Initial, Last) _____ Social Security #: _____