DELTA DENTAL®

Enrollment/Change Form

Choose One:

☐ New Application of Coverage ☐ Change Authorization ☐ Waiver of Coverage (Complete Sections 1 and 6 ONLY)

SECTION 1: EMPLOYEE INFORMATION (Please type or print legibly.)

☐ Add
☐ Terminate

Group Number: _____

Employer/Group Name: (Please do not abbreviate.) _____

Employee Name: (First, Middle Initial, Last) _____

Social Security/ID Number: _____

Home Address: _____ City: _____ State: _____ ZIP: _____ Birth Date: (mm/dd/yy) _____

Email Address: _____

By providing your email address, you agree to receive benefit information, including explanation of benefits online. We value your privacy and use a variety of security measures to protect your personal information. Your email will not be sold or used in any way except for Delta Dental communications. You may change your consent at any time, or request paper documents, by going to the Member Account section of our website. There are no conditions, consequences or fees for withdrawing your consent. You have the right to receive your documents in paper form. If you receive electronic documents, you will need access to hardware and software that supports the latest 2 major browser versions of the following (Chrome, Firefox, Safari and or Internet Explorer 11 or above). Additionally, either your web browser or a suitable plugin for opening a file in portable document format such as Adobe Reader is required. You may update your electronic contact information by calling Customer Service at 800.234.3375, emailing moreinfo@deltadentalks.com or logging into the Member Account at www.deltadentalks.com.

☐ Single
☐ Married

Hire Date: (mm/dd/yy) _____

Effective Date: (mm/dd/yy) _____

Type of Medical Coverage: ☐ Single ☐ Married

Medical Carrier and Address: _____

SECTION 2: DEPENDENT INFORMATION (List ONLY eligible family members to be enrolled or affected by change.)

Action	Effective Date (MM/DD/YY)	Spouse Name (First, Middle Initial, Last)	Birth Date (MM/DD/YY)
☐ Add ☐ Terminate			

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 (MM/DD/YY)	Dependent Name (First, Middle Initial, Last)	Birth Date (MM/DD/YY)
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			

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

Are your dependents covered by another *dental* plan?
Spouse: ☐ Yes ☐ No **Children**: ☐ Yes ☐ No

Dental Carrier: _____ Address: _____

Are your dependents covered by another *medical* plan?
Spouse: ☐ Yes ☐ No **Children**: ☐ Yes ☐ No

Medical Carrier: _____ Address: _____

If yes, please provide the Primary Subscriber's Social Security #: _____ Primary Subscriber's Employer: _____

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 ☐ Loss of Coverage ☐ Adoption/Legal Custody of Child ☐ Other: _____

SECTION 5: AUTHORIZATION/SIGNATURE

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 in dental 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 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: _____

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

Return to Delta Dental of Kansas: **(Please keep a copy for your records.)**
email: eligibility@deltadentalks.com | mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3394

800.234.3375 | DeltaDentalKS.com