DELTA DENTAL

Delta Dental Individual and Family™

MID-YEAR CHANGE FORM

This Change Form should only be completed if you want to make changes to or cancel your Delta Dental Individual and Family Coverage. Please note, member ID cards for all covered member will be sent to the address you provide below.

SECTION 1 - ACCOUNT HOLDER'S CURRENT INFORMATION: **REQUIRED** (Please type or print legibly)

Last Name: ______ First Name: ______ MI: ______

Address: ______

City: ______ ,Kansas ZIP: ______

Social Security No.: ______ Date of Birth: ______

Are you, the Account Holder, enrolling to be covered under the dental plan? ☐ Yes ☐ No

Email: ______ Phone: ______

SECTION 2 - CHANGES: (Please mark all appropriate boxes that apply to changes you wish to make)

☐ Address Change: **From: Address Listed Above** **To:** ______

☐ Add/Terminate Dependents: **Complete Section 3**

☐ Name Change: **Complete Section 4**

☐ Qualifying Events: **Complete Section 4**

☐ Change Payment Method: **Complete Section 5**

☐ Terminate Policy: **Complete Section 7**

SIGN SECTION 6 TO AUTHORIZE CHANGES

SECTION 3 - DEPENDENT INFORMATION: (List ONLY eligible family members to be enrolled or affected by change)

Action	Social Security Number	Spouse Name (First, MI and Last)	Birth Date
☐ Add ☐ Terminate			

Action	Social Security Number	Dependent Name (First, MI) (Last, If Different)	Birth Date
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			

SECTION 4 - QUALIFYING EVENT: (Please mark all appropriate boxes that apply to changes you wish to make)

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

Date of Event: ______ ☐ Name Change: From: ______ To: ______

☐ Marriage ☐ Divorce ☐ Adoption/Legal Custody of Child ☐ Birth ☐ Loss of Coverage

Qualifying Event Documentation must accompany this form for selected event, including but not limited to, Court Order; Marriage License; Divorce Decree; Birth Certificate; and Proof of Prior Dental Coverage for the last 60 days. Coverage is effective the first of the month following the qualifying event.

SECTION 5 - PAYMENT METHOD: (If you wish to change payment method, please indicate below)

Pay by Checking or Savings Account:

Account Type: ☐ Checking ☐ Savings Bank Name: ______

Name on Account: ______

Routing Number: ______ Account Number: ______

SECTION 6 - SIGNATURE/AUTHORIZATION

I hereby authorize Delta Dental of Kansas, Inc. to apply the changes indicated above to my individual dental policy.

Authorization/Signature for Change(s): ______ Date: ______

SECTION 7 - TERMINATION OF COVERAGE: (Complete ONLY if you or your family are cancelling coverage)

DELTA DENTAL OF KANSAS REQUIRES 30 DAYS NOTICE ON TERMINATIONS/QUALIFYING EVENTS PRIOR TO EFFECTIVE DATE

I understand that in the event I should decide to apply for coverage at a later date, I may be subject to waiting periods and/or limitations.

Authorization/Signature for Cancellation of Coverage: ______ Date: ______

Print Name: ______ Social Security Number: ______

Return to Delta Dental of Kansas
eligibility@deltadentalks.com | Fax 316.462.3394 | P.O. Box 789769 Wichita, KS 67278-9769

Questions? Contact us at 800.234.3375