

Please note, member ID cards for all covered member will be sent to the address you provide below. No action is necessary to continue existing coverage, unless the requested changes will alter your premium rate or annual payment is due.

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: _____

Date of Application: _____ Effective Date: _____ (MM/YYYY, month can be up to three months in the future and coverage will begin on the 1st of the month indicated)

Check here if you have been covered under a dental insurance plan within the last 60 days.

Prior Carrier Name: _____ Prior Policy Number: _____ Termination Date: _____

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

Name Change: **From:** _____ **To:** _____
For a Name Change Qualifying Event, documentation must accompany this form. Including, but not limited to, Court Order; Marriage License; or Divorce Decree.

Address Change: **From: Address Listed Above** **To:** _____

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

Change Plan Type: **Complete Section 4**

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
<input type="checkbox"/> Add <input type="checkbox"/> Terminate			

Action	Social Security Number	Dependent Name (First, MI) (Last, If Different)	Birth Date
<input type="checkbox"/> Add <input type="checkbox"/> Terminate			
<input type="checkbox"/> Add <input type="checkbox"/> Terminate			
<input type="checkbox"/> Add <input type="checkbox"/> Terminate			
<input type="checkbox"/> Add <input type="checkbox"/> Terminate			

SECTION 4 - PLAN INFORMATION: (If you wish to change plan types, please indicate below)

Please check the plan you wish to enroll in: Platinum Gold Silver Bronze

Please check the type of coverage you are purchasing: Individual Individual + 1 Family

SECTION 5 - BROKER INFORMATION: (if applicable)

Broker Agency Name: _____ Broker Agency ID: _____

Agent Name: _____ Agent ID: _____

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: _____