DELTA DENTAL®

ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
Fax (501) 992-1890

☐ New Enrollment ☐ Status Change ☐ Address Change ☐ Termination

☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date

Month	Day	Year

Group Number: _____

Group Name: _____

Social Security Number

Subscriber's Identifier (if applicable)

LAST NAME: _____ FIRST: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: ( ) _____

Date of Birth

/ /

MM DD YY

Marital Status

☐ Single

☐ Married

Sex

☐ Male

☐ Female

Date of Hire

/ /

MM DD YY

Other Coverage Info:

Do you have current dental coverage? ☐ Yes ☐ No

Is this coverage intended to replace your current dental coverage? ☐ Yes ☐ No

What is the name of your current carrier?

_____

COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

Vision	Dental
☐ Employee	☐ Employee
☐ Employee/Spouse	☐ Employee/Spouse
☐ Employee/Child	☐ Employee/Child
☐ Employee/Children	☐ Employee/Children
☐ Employee/Family	☐ Employee/Family

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change
☐ Late Entrance (employee)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other _____

☐ COBRA effective date _____

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Date of event_____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student

LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Vision	Dental		Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
☐	☐	☐ Add ☐ Remove						
☐	☐	☐ Add ☐ Remove						
☐	☐	☐ Add ☐ Remove						
☐	☐	☐ Add ☐ Remove						
☐	☐	☐ Add ☐ Remove						
☐	☐	☐ Add ☐ Remove						

AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time**.
☐ I authorize payroll deductions.

Signature:_____ Date: _____