DELTA DENTAL®

Eligibility Enrollment/Update

Check: ◉ **Indiana** ○ **Michigan** ○ **North Carolina** ○ **Ohio**

Client Name: _____ Client#/Subclient# _____ - _____

Subscriber Information *(please complete for all enrollments/updates:)* Example: ABCDEF123456

Subscriber Name (Last) _____ (First) _____ (M.I.) _____ Sex ○ Male ○ Female Status* ○ Active ○ COBRA ○ Retiree ○ Surviving

Subscriber Social Security Number ___ - ___ - ___ Birth Date ___ - ___ - ___ Coverage Effective Date ___ - ___ - ___ Hire Date ___ - ___ - ___

Street Address _____ ○ Check here if this is a new address Email _____

City _____ State _____ ZIP Code _____ - _____

Plan Enrollment/Update Information *(please indicate type of update and fill in appropriate information):*

Type of Update: ○ New Enrollment ○ Reinstatement ○ Change/Correction to Information ○ Termination of Benefits ○ Waive Benefits

Group Transfer From: Client/Subclient# _____ - _____ To: Client/Subclient# _____ - _____

Rate Code Change* From: _____ To: _____

Effective Date of Change ___ - ___ - ___

Change is for: ○ Subscriber ○ Dependent

Enrollment/Corrections to Information *(please fill in for spouse/dependents for first-time enrollment or corrections):*

SPOUSE Name (Last) _____ (First) _____ (M.I.) _____ Sex ○ Male ○ Female

Social Security Number ___ - ___ - ___ Birth Date ___ - ___ - ___ Status* ○ Legal ○ Surviving

DEPENDENT #1 Name (Last) _____ (First) _____ (M.I.) _____ Sex ○ Male ○ Female

Social Security Number ___ - ___ - ___ Birth Date ___ - ___ - ___ Status* ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

DEPENDENT #2 Name (Last) _____ (First) _____ (M.I.) _____ Sex ○ Male ○ Female

Social Security Number ___ - ___ - ___ Birth Date ___ - ___ - ___ Status* ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

DEPENDENT #3 Name (Last) _____ (First) _____ (M.I.) _____ Sex ○ Male ○ Female

Social Security Number ___ - ___ - ___ Birth Date ___ - ___ - ___ Status* ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

DEPENDENT #4 Name (Last) _____ (First) _____ (M.I.) _____ Sex ○ Male ○ Female

Social Security Number ___ - ___ - ___ Birth Date ___ - ___ - ___ Status* ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

1 Subscriber's Signature _____ Date _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your group continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**

Surviving: The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled “from” and the correct information should be listed on the line titled “to”.

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Delta Dental program.

Rate Codes:

- **Rate 1** Employee Only
- **Rate 2** Employee and spouse
- **Rate 3** Employee, spouse and children
- **Rate 5** Employee, one child, no spouse
- **Rate 6** Employee and more than one child, no spouse

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse

Surviving: The surviving spouse or child of a deceased subscriber.

IRS Dependent: An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, **but only if specified in your group’s contract with Delta Dental.**

Delta Dental
Attention: Eligibility Department
P.O. Box 30416
Lansing, MI 48909-7916