

DUAL CHOICE ENROLLMENT/CHANGE FORM

Select a Program:

Delta Dental DeltaCare*
(Not available in all areas)



For Employer Use Only	
Effective Date	Group No.
Full Time Hire Date	Sublocation

*DeltaCare is administered by Private Medical-Care, Incorporated (PMI).

Check One (*Enrollees can change plans only during open enrollment)

New Hire

Open Enrollment

Change Dental Plans**

COBRA

Add/Delete Dependent

Terminate Employee Coverage

Spouse Employment Change

Marital Change

Other _____

Indicate qualifying date: _____

(Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

Termination

Reduction in Hours

Divorce

Widowed/Surviving Dependent

Dependent Child No Longer Eligible

Indicate qualifying date: _____

(Month) (Day) (Year)

Delta Dental - CANCEL

DeltaCare - CANCEL

Delta Dental - 1-800-521-2651

DeltaCare - 1-800-422-4234

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____ (Last, First, Middle)

Mailing Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zip)

Social Security # _____ (9 - - - - -) Date of Birth: _____ (Month) (Day) (Year)

Name of Employer/Group _____ Location _____

Marital Status: Single Married Gender: Male Female Phone # (_____) _____

Do you have dependent children? Yes No Are you or your dependents covered under another dental plan? Yes No

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

	Add	Delete	Male	Female					
Spouse:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of Birth:	____/____/____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of Birth:	____/____/____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of Birth:	____/____/____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of Birth:	____/____/____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of Birth:	____/____/____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of Birth:	____/____/____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>

DeltaCare

Dentist Name: _____ Provider # _____ Location (State) _____

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.