DELTA DENTAL®

ENROLLMENT/STATUS CHANGE FORM

☐ ~~Delta Dental Premier~~ ☐ ~~Delta Dental PPO~~ ☐ Delta Dental PPO Plus Premier ☐ DeltaCare

Delta Dental Premier, Delta Dental PPO and Delta Dental PPO Plus Premier are offered by Delta Dental of Kentucky, Inc.

DeltaCare is offered by Dental Choice, Inc.

☐ OPEN ENROLLMENT ☐ NEW ENROLLMENT ☐ STATUS CHANGE ☐ COBRA _____

Complete Status Change information below. *COBRA effective date.*

Social Security Number	Name – Last	First	MI	Birthdate / /

Home Address – Number and Street	City	State	Zip	Group Number
				694790

Sex (Circle one)	Employer Name	Hire Date Required	Section Number
M or F	Taylor Made Sales Agency / Taylor Made Stallions	/ /	

Check the type of contract and list all members:

☐ Single ☐ Employee and Spouse ☐ Employee and child ☐ Employee and children ☐ Family

MEMBERS Please list all dependents below, if applicable. If additional space is required, attach a list to this form.

Last	First	MI	Date of Birth MO	DAY	YR	Sex M	F	FULL-TIME STUDENT YES*	NO	STATUS CHANGES ONLY (Circle one)	Does member have other dental coverage? If so, give insurance company name and telephone number, policyholder's name and identification number.
Spouse										ADD DELETE	
Dependent										ADD DELETE	
Dependent										ADD DELETE	
Dependent										ADD DELETE	
Dependent										ADD DELETE	

Dependent children coverage requiring student verification once they have turned age 19 must submit proof of full-time school enrollment. A signed Delta Dental affidavit is acceptable.

STATUS CHANGES ONLY (Complete all that apply. Qualifying event required.)

Indicate new contract type below and add or delete dependents in MEMBERS grid above:

☐ Single ☐ Employee and Spouse ☐ Employee and child ☐ Employee and children ☐ Family

Qualifying Event: _____ **QE Effective Date:** _____

Terminate Subscriber's Contract as of _____

_____

Name Change: Previous Name: _____ **New Name:** _____

Address Change: _____

SHADED AREA FOR OFFICE USE ONLY

Effective Date	Process Date	Processed By

READ THE PROVISIONS ON THE BACK OF THIS ENROLLMENT FORM CAREFULLY BEFORE SIGNING.
PLEASE REVIEW YOUR ENROLLMENT FORM FOR ERRORS OR OMISSIONS.

I acknowledge I have read the provisions on the back of this enrollment form and I expressly accept such provisions as a condition of coverage. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Dental Choice (DeltaCare) or Delta Dental (Delta Dental Premier and Delta Dental PPO) in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). If accepted, this form, the member certificate, the identification card, and the group contract will constitute the contract.

Signature _____ Date _____

Please make a copy for your records and return original to your Human Resources Director.