

Delta Dental

Enrollment/Change Form

Effective Date: _____

Hire Date: _____

Employee Name: _____

SSN: _____

Employee Address: _____

DOB: _____

City/State/Zip: _____

Sex: _____

Group Name: _____

Group Number: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Are you enrolling dependents? ___ Yes ___ No

Does spouse have a dental plan? ___ Yes ___ No

*List Names of Eligible Dependents:

Last Name (if different)	First	MI	Sex	Birthdate
(spouse)	_____			
(children)	_____			

CHANGE in Marital Status or Coverage:

Marriage Date: _____

Divorce Date: _____

Other (Explain): _____

**Signature: _____

Date: _____

**I agree to and accept the provisions indicated on the 2nd page of this form.

Enrollment*

***I understand that should I decide to apply for single coverage only even though I am eligible for family coverage, any subsequent application would be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Care Benefits, which may require additional limitations and waiting periods. I also understand the Delta Dental Plan of South Dakota reserves the right to reject such application.**

****I accept the insurance provided by my employer's group dental plan and authorize deductions from my earnings for the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required. I understand that by accepting insurance, I am required to remain enrolled as a covered employee until the next open enrollment period or until the termination of my employment.**

Coordination of Benefits

This plan's administration of Coordination of Benefits allows those benefits of the secondary plan plus those of the primary plan may not exceed 100% of the allowable expenses.