



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			Group Number: _____			Social Security Number		
Month	Day	Year	Group Name: _____			Subscriber's Identifier (if applicable)		

LAST NAME: _____ FIRST: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: () _____

Date of Birth Marital Status Sex Date of Hire
 Single Male
 Married Female
 MM / DD / YY 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		<input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> Remove Dependent(s) listed below <input type="checkbox"/> Name Change <input type="checkbox"/> Late Entrance (employee) Reason(s) for Change: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth or adoption of child <input type="checkbox"/> Full Time Student <input type="checkbox"/> Handicapped <input type="checkbox"/> Other _____ <input type="checkbox"/> COBRA effective date _____
<input type="checkbox"/> Employee	<input type="checkbox"/> Employee	<input type="checkbox"/> Change Coverage	<input type="checkbox"/> Address Change only
<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Qualifying event	<input type="checkbox"/> Late Entrance (dependent)
<input type="checkbox"/> Employee/Child	<input type="checkbox"/> Employee/Child	Date of event _____	<input type="checkbox"/> Loss of spouse's coverage
<input type="checkbox"/> Employee/Children	<input type="checkbox"/> Employee/Children	<input type="checkbox"/> No longer dependent child	<input type="checkbox"/> Death of dependent
<input type="checkbox"/> Employee/Family	<input type="checkbox"/> Employee/Family	<input type="checkbox"/> 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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> 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: _____ DDVIS06A-06