

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM



Delta Dental Plan of Illinois

PLEASE KEEP A COPY FOR YOUR FILES.

Please note that completing this form does not guarantee coverage.

ALL GROUPS MUST COMPLETE THIS SECTION

Note: Incomplete forms will be returned.

Delta Dental Group Number _____ Sublocation Number _____	DDPIL USE ONLY
Date of Hire _____ OR Date of Rehire _____	Effective Date _____ Rate Code _____
Reinstatement Due to Qualifying Event? <input type="checkbox"/> Yes <input type="checkbox"/> No	COB _____ ASC _____
If yes, please describe _____	Store loc _____
Group Contact _____ Phone _____ Email _____	

ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS

Please check one of the options below.

- Yes**, I want to enroll in the dental plan offered by Delta Dental Plan of Illinois.
- No**, I do not want to enroll in the dental plan offered by Delta Dental Plan of Illinois. (If you are declining, please write your name below and sign at the bottom of this form)

Employee's Name _____ Phone Number _____ Male Female
First Name Last Name

Mailing Address _____
Street City State Zip

Social Security Number _____ Date of Birth ____ / ____ / ____ Marital Status: S M Other

Name of Employer _____ Location/Department _____

Hourly Salaried Union Non-Union Other

REASON FOR SUBMITTING THIS FORM

Open Enrollment *If DeltaCare (DHMO) enrollment:* Dentist Name: _____ Address: _____ Facility Code: _____

New Employee Reinstatement Change If this is for a change, what is the reason? _____

Address Change Termination (Reason: _____)

Add Dependent Coverage (List Dependents below)* (Reason: _____) Date of Event: _____

Drop Dependent Coverage (List Dependents below)* (Reason: _____) Date of Event: _____

*If you are adding or dropping a dependent due to a qualifying event, please describe: _____

Name Change (Former Name: _____)

Dentist Change (*DeltaCare DHMO only*): Dentist Name: _____ Address: _____ Facility Code: _____

COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family None – waive

Effective Date: ____ / ____ / ____ Does spouse have a dental plan? Yes No Are dependents covered by spouse's plan? Yes No

Employer: _____ Carrier: _____

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (Month/Day/Year)	SEX (M or F)
		1. Spouse:			
		2. Child:			
		3.			
		4.			
		5.			

I agree to continue membership in this program until the next open enrollment period and authorize payroll deduction where applicable.

Signature of applicant: _____ Date: _____

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Phone (630) 964-2400 • Fax (630) 964-2997 • Email eligibility@deltadentalil.com