

DENTAL ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
 P.O. Box 15965
 North Little Rock, AR 72231
 E-mail: eligibility@ddpar.com

- New Enrollment Status Change Address Change
 Termination Cobra

Effective Date: _____ Group Number: _____

Month	Day	Year

 Group Name: _____

Social Security Number

Subscriber's Identifier (if applicable)		

LAST NAME: _____ FIRST: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: () _____

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code." Enter P for pregnant, D for diabetes, and H for Heart Disease)

Date of Birth Marital Status Sex Date of Hire

Single Male
 Married Female

MM / DD / YY MM / DD / YY

- Pregnancy - Expected due date _____
 Diabetes - Date of onset _____
 Heart Disease - Date of onset _____

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

- Type coverage selected (choose one)
- Employee
 Employee/Spouse
 Employee/Child
 Employee/Children
 Employee/Family

- Add Dependent(s) **listed below**
 Remove Dependent(s) **listed below**
 Name Change
 Late Entrance (employee)
 Reason(s) for Change:
 Marriage
 Divorce
 Birth or adoption of child
 Full Time Student
 Handicapped
 Other _____
 COBRA effective date _____

- Change Coverage
 Address Change only
 Qualifying event
 Late Entrance (dependent)
 Date of event _____
 Loss of spouse's coverage
 No longer dependent child
 Death of dependent
 No longer Full Time Student

Other Coverage Info:
 Do you have current dental coverage? Yes No
 Is this coverage intended to replace your current dental coverage? Yes No

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								

3. 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.

4. 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 program through Delta Dental; however, **I waive coverage at this time.**
 I authorize payroll deductions.

Signature: _____ Date: _____