DELTA DENTAL

SECTION F: Employer Use Only

Employer Name: _____

Effective Date: _____/_____/_____ (MM/DD/YYYY)

Enrollment Application/Change of Status Form

Instructions on reverse side.

SECTION A: Qualifying Event

☐ **NEW HIRE** (Complete sections B, C, D, E)

☐ **OPEN ENROLLMENT** (Complete sections B, C, D, E)

- ☐ Dental
  - ☐ Premier
  - ☐ PPO plus Premier
  - ☐ PPO
  - ☐ enhanced Premier
- ☐ Vision

☐ **DECLINE COVERAGE** (Complete sections B, D, E)

- ☐ Dental ☐ Vision

☐ **CHANGE OF STATUS** (Complete sections B, C, D, E)

- ☐ Dental ☐ Vision
- ☐ Cancel Coverage (Complete section B, E) ☐ COBRA (Complete sections B, C, D, E)
- ☐ Address Change (Complete section B, E)
- ☐ Name Change To: _____ From: _____
- ☐ Add/Delete Dependent(s) (Complete sections B, C, E)
  - ☐ Marriage ☐ Birth ☐ Retire
  - ☐ Divorce ☐ Adoption ☐ Loss of Coverage ☐ Other - Reason: _____

SECTION B: Employee Information

Social Security Number/EIN	Employer Name		
Employee's Last Name	First	MI	Marital Status ☐ Single ☐ Married Gender ☐ M ☐ F
Home Address (Mailing)			Date of Birth_____/_____/_____ (MM/DD/YYYY)
City	State	Zip	Email

SECTION C: Dependent Information

Add	Change	Delete	Last Name (If different), First, MI	Dental	Vision	Relationship to Employee	Gender M / F	Date of Birth	Full-Time Student Y / N
☐	☐	☐		☐	☐			_____/_____/_____ MM DD YYYY	
☐	☐	☐		☐	☐			_____/_____/_____ MM DD YYYY	
☐	☐	☐		☐	☐			_____/_____/_____ MM DD YYYY	
☐	☐	☐		☐	☐			_____/_____/_____ MM DD YYYY	

SECTION D: Other Coverage Information

Do you or any member of your family have coverage under another group dental insurance plan? ☐ YES – Please check the appropriate box(es) and complete Section D ☐ NO – Please skip to Section E

☐ Medical ☐ Dental ☐ COBRA ☐ Retiree ☐ Vision

Insurance Company Name		Policyholder's Social Security Number
Name of Policyholder		
Employer Name	Policyholder's Date of Birth _____/_____/_____ (MM/DD/YYYY)	Effective Date of Coverage _____/_____/_____ (MM/DD/YYYY)

Please indicate to whom this coverage applies (Check all that apply). ☐ Self ☐ Spouse ☐ All Children ☐ Child(ren) _____ Name(s)

Name of Dependent	Relationship to Policyholder

SECTION E: Authorization

I hereby apply for coverage with Delta Dental of Arizona pursuant to the terms specified on the reverse side of this form, which are hereby incorporated by reference.

_____ Employee's Signature/Authorization

_____ Date Signed (MM/DD/YYYY)

_____ Employer's Signature/Authorization

_____ Date Signed (DD/MM/YYYY)

DDAZ-0002-rev0615

I apply for benefits with Delta Dental of Arizona (Delta Dental), and on behalf of any dependents and myself, I agree to be bound by the provisions of my dental or vision plan (the Plan). If accepted, this application, the identification card and the group contract will constitute the Plan.

I understand and agree that my coverage and that of any dependents will become effective on the date established by my employer in Section F. Any dependents that are added to my Plan later will have different effective dates.

My employer or group administrator is authorized to deduct my share of dental premiums, if any, from my wages for 12 months and during any renewal periods. My employer or group administrator is authorized to remit a premium to Delta Dental and to receive all notices from Delta Dental relating to my coverage. I understand that enrollment is for consecutive 12-month period, and my contribution is subject to change on renewal. Further, I understand that non-compliance with these terms voids any benefits during an enrollment period.

I will notify Delta Dental upon any change that would make me or any dependent ineligible for coverage.

I will cooperate with Delta Dental and furnish all information requested to enforce Delta Dental's right to coordinate benefits.

I understand that Delta Dental may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. If false or misleading information is discovered, Delta Dental may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application. Any claims paid during the periods when the coverage was not in force will be deducted from the premium refund. If the benefits paid by Delta Dental exceeds the premium paid, I agree to refund any excess amount to Delta Dental.

Uses and Disclosures of Health Information: At Delta Dental, we use health information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. For more information about our privacy practices, please visit www.deltadentalaz.com under privacy policy or contact Customer Service, Phone: 602.938.3131 or 800.352.6132, Email: customerservice@deltadentalaz.com.

Instructions

SECTION A - Determine the Qualifying Event

Please check or complete all boxes that indicate whether you are a new enrollee or you are requesting an update to your current coverage. If you are requesting a coverage update, select the appropriate qualifying event and indicate the date of the event.

New Hire/Open Enrollment: Select the dental plan offered by your employer. If vision is being offered and you would like to apply for coverage, please check the vision box. Please complete Sections B, C, D, and E.

Decline Coverage: If you would like to decline dental or vision coverage, please check the dental and/or vision option. Please complete sections B, D, and E.

Change of Status:

- **Cancel Coverage** - Check the Cancel Coverage box and complete sections B and E.
- **COBRA** - Check the COBRA box and complete sections B, C, D, and E.
- **Address Change** - Check the address change box and complete section B and E.
- **Add/Delete Dependent(s)** - Please indicate the qualifying event add the date of the event. Please complete sections B, C, and E.

SECTION B - Employee Information

Please complete this section in its entirety for all circumstances.

SECTION C - Dependent Information

Check either add, change or delete to select the appropriate dependent action. Complete dependent information and select the dental or vision option to apply for coverage or to make the selected updates.

SECTION D - Other Coverage Information

Complete this section if you or any of your dependents have additional dental coverage that will not be cancelled when this plan becomes effective.

SECTION E - Authorization

Once you have completed the appropriate sections and reviewed the terms above, please sign and date this form.
Employer: Sign and date this form before submitting to Delta Dental of Arizona.

SECTION F - Employer Use Only

Submit the signed form to your employer, who will complete section F.
Employer: Complete section F before submitting to Delta Dental of Arizona.