ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

DELTA DENTAL

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_____ ☐ Salaried ☐ Hourly

Effective Date _____ Date of Hire_____ OR Date of Rehire _____ ☐ Non-Union ☐ Union

Name of Employer _____ Location/Department _____ ☐ Other_____

Group Contact_____ Phone_____ Group Contact Email _____

EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

☐ **Yes**, I want to enroll in the dental and/or vision benefit plan(s) offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

☐ Delta Dental PPO/Delta Dental Premier If applicable: ☐ High Option ☐ Low Option

☐ DeltaCare DHMO (please complete the section below)

Dentist Name _____ Address _____ Facility Code _____

☐ DeltaCare DHMO Dentist Change (please complete the section below)

Dentist Name _____ Address _____ Facility Code _____

☐ DeltaVision®

☐ **No**, I do not want to enroll in the dental benefit plan.

☐ **No**, I do not want to enroll in the vision benefit plan. *(If you are declining, please write your name below and sign at the bottom of this form.)*

Social Security Number _____ Employee's Name _____
(First Name, MI, Last Name)

Alternate ID # _____ # Hours Worked _____ Job Title_____

Mailing Address_____
(Street, City, State, Zip)

Email Address _____ Phone Number _____

Marital Status: ☐ S ☐ M ☐ Other Date of Birth ____/____/____ ☐ Male ☐ Female

REASON FOR SUBMITTING THIS FORM

☐ Initial or Open Enrollment ☐ COBRA COBRA End Date ____/____/____ ☐ Retiree

☐ Reinstatement due to: ○ Rehire ○ Loss of Other Coverage ○ Other _____

☐ Add Dependent (list below) due to:

○ Birth ○ Adoption ○ Marriage ○ Loss of Other Coverage ○ Legal Guardianship ○ Disabled Dependent

○ Military Dependent ○ Other _____ Date of Qualifying Event ____/____/____

☐ Drop Dependent (list below) due to:

○ Age ○ Death ○ Divorce ○ Other Coverage Elsewhere Date of Qualifying Event ____/____/____

☐ Termination of Employment Date ____/____/____ ☐ Covered Under Spouse Date ____/____/____

☐ Name Change (Former Name _____) ☐ Address Change

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/dd/yyyy)	SEX (M or F)
☐	☐	1. Spouse:			
☐	☐	2. Child:			
☐	☐	3.			
☐	☐	4.			
☐	☐	5.			

DENTAL COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & One Child ☐ Employee & Children ☐ Entire Family

Is spouse covered under another dental plan? ☐ Yes ☐ No Other Carrier Name _____

Are dependents covered by spouse's plan? ☐ Yes ☐ No Spouse's Carrier _____

Spouse's Employer _____

VISION COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & One Child ☐ Employee & Children ☐ Entire Family

I am requesting the coverage(s) I have selected above for which I am eligible under the contract issued by Delta Dental of Illinois for dental coverage and/or by TruAssure Insurance Company for vision coverage. I agree to continue membership in this program until the next open enrollment period. I certify that all the information stated on this form is complete and true to the best of my knowledge and Delta Dental of Illinois/TruAssure Insurance Company believing it to be true shall rely and act upon it accordingly. I authorize my employer/group to deduct from my pay and remit any required contributions for the cost of the selected coverage. This authorization is to remain in effect until Delta Dental of Illinois/TruAssure Insurance Company is notified in writing to the contrary.

Signature of Applicant _____ Date _____

*Please Note: DeltaVision® is provided by TruAssure Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 369-0384 • Email eligibility@deltadentalil.com