



SMALL BUSINESS PROGRAM ENROLLMENT/CHANGE FORM



Enrollment guidelines (except for PPO Vol):

1. Eligible employees electing coverage for themselves must enroll following completion of their eligibility period. Employees who do not enroll **cannot enroll at a later time** unless they show proof of loss of prior coverage under another dental program.
2. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage under another dental program.

Policy Information

Company/Group Name	Delta Dental plan (check one) <input type="checkbox"/> Delta Dental PPO sm <input type="checkbox"/> DeltaCare [®] USA	Employer #
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Reasons For Addition/Change (check one)

<input type="checkbox"/> New hire	<input type="checkbox"/> Part-time to full-time (give date of full-time start date)	<input type="checkbox"/> Dependent change (provide reason & date of qualifying event)
<input type="checkbox"/> Loss of coverage (provide proof — letter from prior carrier/employer)	<input type="checkbox"/> Fed-COBRA enrollment (provide termination date)	<input type="checkbox"/> Name or SS # correction (provide old and new number or SS #)
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Rehire (note rehire date) _____	<input type="checkbox"/> Reinstatement
<input type="checkbox"/> Other (please explain) _____		

Comments:	Effective date:
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Enrollee Information

Enrollee name (Last name, first name)	Social security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	Date of hire
Mailing address	City	State	ZIP	Phone

Dependents to be Enrolled or Deleted

Spouse/domestic partner name (last, first)	<input type="checkbox"/> Add <input type="checkbox"/> Term	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	
Child name (Last, First)	<input type="checkbox"/> Add <input type="checkbox"/> Term	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	If 19 years or older check one: <input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled
	<input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled
	<input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled
	<input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled <i>*Provide proof of full-time student status</i>

DeltaCare USA Enrollees Must Fill Out This Section

Provider choice: Dental office ID #	Dental office city	Dental office name
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Signature

Enrollee signature	Date
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This form must be received no later than the 25th of the month prior to the desired effective date. Please allow 5 days to process.