

**Check One:**

- New Application for Coverage  
 Change Authorization  
 Waiver of Coverage (complete Section (6) ONLY)

# Enrollment/Change Form

**Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)**

Add <input type="checkbox"/>	Social Security / ID Number:	Group Number:	Employer/Group Name: (Please do not abbreviate)	
Terminate <input type="checkbox"/>				
Employee Name: (First, Middle Initial, Last)				Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Address:		City:	State:	Zip Code:
				Birth Date: (mm/dd/yy)
Single <input type="checkbox"/>	Hire Date: (mm/dd/yy)	Effective Date: (mm/dd/yy)	Type of Medical Coverage:	Medical Carrier and Address:
Married <input type="checkbox"/>			Single <input type="checkbox"/> Family <input type="checkbox"/>	

**Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)**

Action:	Effective Date:	Spouse Name: (First, Middle Initial, Last)		Birth Date:	
Add <input type="checkbox"/>	(mm/dd/yy)		Male <input type="checkbox"/>		
Terminate <input type="checkbox"/>			Female <input type="checkbox"/>		
NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:					
Action:	Effective Date:	Dependent Name: (First, Middle Initial) (Last Name, if different)	Male	Female	Birth Date:
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>					

**Section 3 OTHER INSURANCE INFORMATION: (Complete ONLY if requesting coverage for dependent[s])**

		Spouse	Children	Dental Carrier:
Are your dependents covered by another dental plan?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Address:
Are your dependents covered by another medical plan?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
If YES, please provide spouse's Social Security #: _____				Medical Carrier:
Spouse's employer: _____				Address:

**Section 4 CHANGES: (Please mark all appropriate boxes that apply to change[s] you wish to make)**

**DELTA DENTAL MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT**

DATE of EVENT: \_\_\_\_\_

Name Change: From: \_\_\_\_\_ To: \_\_\_\_\_

Marriage:       Divorce:       Other:

Adoption/Legal Custody of Child:

**Section 5 SIGNATURE/AUTHORIZATION:**

I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.

Authorization/Signature for Enrollment/Change[s]: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 6 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)**

This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer, and I have decided that I:

**Do not** want dental coverage for myself because: \_\_\_\_\_  
 **Do not** want dental coverage for my spouse and/or my children.

I understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed-Employee Name: (First, Middle Initial, Last) \_\_\_\_\_ Social Security #: \_\_\_\_\_