DELTA DENTAL

P.O. Box 8690; St. Louis, MO 63126
314-656-3000 or 800-392-1167

☐ New Application for Coverage Complete Section 1, 2, and 4.

☐ COBRA - Complete Sections 1, 2, 4 and the COBRA item in Section 3 if applicable.

☐ I do not wish to enroll.

☐ Change/Subscriber Authorization Form Section 1 and 4 must be completed. Section 2 and 3, complete as applicable for change requested.

Group Name: _____

Group#/Sublocation# ☐☐☐☐ - ☐☐☐☐

Division/Sublocation _____

If applicable:
☐ High Option
☐ Low Option

SECTION 1 EMPLOYEE INFORMATION

Employee Last Name: _____ First Name: _____ Sex: ☐ M ☐ F

Social Security No. ☐☐☐☐☐☐☐☐☐ Alternate ID Number * ☐☐☐☐ ☐☐☐☐☐☐☐☐☐ Birth Date (mm/dd/yyyy): ___ / ___ / _____

Street Address: _____ Coverage Effective Date: ___ / ___ / _____

City: _____ State: _____ Zip Code: _____ ☐ Check here if this is a new address.

Employee Hire Date: ___ / ___ / _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

A. Does your spouse have any other group dental coverage? ☐ Yes ☐ No
B. If yes to A, are you covered by your spouse's plan? ☐ Yes ☐ No
C. If yes to A, are your dependents covered by your spouse's plan? ☐ Yes ☐ No
D. If yes to A, is the other group dental coverage through a retiree plan? ☐ Yes ☐ No
E. If yes to B or C, provide the name of your spouse's dental plan _____

* For employer groups who utilize Alternate ID numbers, the assigned group number is the first four digits of the Alternate ID. You are still required to submit your SSN on the application for claims processing purposes.

SECTION 2 SPOUSE AND DEPENDENT INFORMATION

Please complete for spouse/dependents to be enrolled or cancelled. Use a 2nd form for additional dependents if needed.

☐ Enroll ☐ Cancel **Spouse** - Last Name _____ First Name _____ Sex ☐ M ☐ F
Birth Date (mm/dd/yyyy): ___ / ___ / _____

☐ Enroll ☐ Cancel **Dependent #1** - Last Name _____ First Name _____ Sex ☐ M ☐ F
Birth Date (mm/dd/yyyy): ___ / ___ / _____ Relationship: ☐ Child ☐ Other _____

☐ Enroll ☐ Cancel **Dependent #2** - Last Name _____ First Name _____ Sex ☐ M ☐ F
Birth Date (mm/dd/yyyy): ___ / ___ / _____ Relationship: ☐ Child ☐ Other _____

☐ Enroll ☐ Cancel **Dependent #3** - Last Name _____ First Name _____ Sex ☐ M ☐ F
Birth Date (mm/dd/yyyy): ___ / ___ / _____ Relationship: ☐ Child ☐ Other _____

☐ Enroll ☐ Cancel **Dependent #4** - Last Name _____ First Name _____ Sex ☐ M ☐ F
Birth Date (mm/dd/yyyy): ___ / ___ / _____ Relationship: ☐ Child ☐ Other _____

IMPORTANT: For court ordered dependents, legal documentation must be attached. If your dependent meets the qualifications for full-time student status, necessary documentation is required.

CONTINUED ON NEXT PAGE. No action requested can be taken without your signature.

SECTION 3 COVERAGE TYPE SELECTION/REASON FOR CHANGE

Select appropriate coverage type:

☐ Employee Only Coverage ☐ Employee and Spouse ☐ Family ☐ Employee and Child/Children

Name Change:

From: Last Name: First Name:

To: Last Name: First Name:

Reason for Change: *All changes must be made within 31 days of the qualifying event.*

Additions:

Effective Date of Addition: ___ / ___ / _____

- ☐ Birth
- ☐ Marriage
- ☐ Adoption (attach legal documentation)
- ☐ Court ordered dependent (attach documentation)
- ☐ Annual Open Enrollment
- ☐ Other (describe)_____

Cancellations:

Effective Date of Cancellation: ___ / ___ / _____

- ☐ Death
- ☐ Employee terminated on ___ / ___ / _____
- ☐ Divorce
- ☐ Dependent reached student/dependent maximum age
- ☐ Retired

Transfer Membership: Effective Date of Transfer ___ / ___ / _____

From: Group#/Sublocation# ☐☐☐☐ - ☐☐☐☐
Division/Sublocation _____

To: Group#/Sublocation# ☐☐☐☐ - ☐☐☐☐
Division/Sublocation _____

COBRA Membership: If new COBRA participant was previously covered as a dependent of another membership, please list that covered employee's social security number and name:

Social Security No. ☐☐☐☐☐☐☐☐☐ Last Name: First Name:

SECTION 4

I represent that the information I have provided on this form is complete and accurate. I request the group coverage to which I am entitled, or may become entitled, under the provision of the Membership Certificate/Master Policy issued by Delta Dental of Missouri. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this membership. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I also authorize any dentist or other provider of care to furnish Delta Dental of Missouri any necessary information regarding care or treatment of myself or any covered dependents. I understand that Delta Dental of Missouri any necessary information regarding care or treatment of myself or any covered dependents. I understand that courses of dental treatment which began before my effective date may not be covered. Please note that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract.

Employee's Signature: Date:

No action requested can be taken without your signature above.