

Enrollment/Change Form

DELTA DENTAL OF IDAHO
555 E. Parkcenter Blvd
Boise, ID 83706
(208) 489-3582

☐ Enrollment Form: Complete Sections I-III

☐ Change Form: Complete Sections I-IV

I. EMPLOYEE INFORMATION (Please print)

Name (First)	(Middle Initial)	(Last)	Subscriber Number or SSN#	Date of Birth	Gender
					☐ Male ☐ Female
Mailing Address (PO Box or RR)			City, State, Zip		
Telephone #:	Date Employed Full-time:	# Hours Worked/Week:	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed		
E-mail Address:			By providing my email address, I agree to receive communications regarding my Policy electronically. This authorization may be revoked by calling Customer Service at (800) 356-7586.		
Name of Employer:		For Employer Use	Group Number:	Effective Date:	

II. DEPENDENT INFORMATION (List all family members you wish to enroll)

	Relationship to Applicant	SSN#	Dependent's Name (First, MI, Last)	Gender	Date of Birth (mo/day/year)
☐ Add	☐ Spouse ☐ Child			☐ Male	
☐ Remove	☐ Stepchild ☐ Other			☐ Female	
☐ Add	☐ Spouse ☐ Child			☐ Male	
☐ Remove	☐ Stepchild ☐ Other			☐ Female	
☐ Add	☐ Spouse ☐ Child			☐ Male	
☐ Remove	☐ Stepchild ☐ Other			☐ Female	
☐ Add	☐ Spouse ☐ Child			☐ Male	
☐ Remove	☐ Stepchild ☐ Other			☐ Female	
☐ Add	☐ Spouse ☐ Child			☐ Male	
☐ Remove	☐ Stepchild ☐ Other			☐ Female	

III. OTHER DENTAL COVERAGE (Medical coverage information is not required)

Do you or your dependents have <u>dental coverage</u> under another benefit plan? ☐ Yes ☐ No If yes, please complete this section			
Name of Covered Person	Name of Covered Person's Place of Employment	Relationship to You	Date of Birth (mo/day/year)
Name of Dental Carrier	Dental Carrier's Address	Covered Person's Group #	
Are you and all dependents listed above on the plan? _____			
☐ Yes ☐ No If No, please list covered dependents. _____			

IV. CHANGE REQUESTS

Change current enrollment due to: ☐ Loss of previous coverage ☐ Marriage ☐ Divorce ☐ Birth ☐ Death ☐ Other _____ Date event occurred _____	
Change my address to:	Change my email to:
Change my name from:	To:

I hereby apply for the group coverage for which I may be eligible, and I authorize the release of my records to Delta Dental of Idaho.
I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.

Employee Signature: _____ Date: _____

Delta Dental of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(800) 356-7586.
注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-(800) 356-7586.