Delta Dental of Illinois Enrollment/Change of Status Form for Group/Employer Dental Policy

Please type or print in black ink and complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

MEMBER

Last Name	First Name	Middle Initial	Date of Birth
			___/___/____

Gender	Marital Status	Social Security Number or Alternate ID Number
	☐Married ☐Single ☐Divorced ☐Widowed ☐Civil Union ☐Domestic Partnership	

Mailing Address	City	State	ZIP

Phone Number	Email Address
( )	

Name of Group/Employer	Group/Employer Number	Sublocation Number
MISSVIC - Edwardsville School District #7	02060	(if applicable) n/a

Requested Effective Date of Coverage	Date of Hire/Rehire
___/___/____	___/___/____

MEMBER/DEPENDENT ADDITIONS/CHANGES

Please check two of the options below.

☐ **Yes,** I want to enroll in this group/employer dental benefit plan offered by Delta Dental of Illinois.

☐ **No,** I do not want to enroll in this group/employer dental benefit plan offered by Delta Dental of Illinois.

CONTINUED ON NEXT PAGE

REASON(S) FOR SUBMITTING THIS FORM

☐ **Initial or Open Enrollment**

☐ **COBRA**
End Date ___/___/_____

☐ **Retiree**

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

☐ **Add Dependent due to:**
☐ Birth ☐ Adoption/Placement for Adoption ☐ Marriage ☐ Domestic Partnership
☐ Civil Union ☐ Legal Guardianship ☐ Loss of Other Coverage
☐ Dependent Child with Disability ☐ Military Dependent ☐ Court Order ☐ Other _____
Date of Qualifying Event ___/___/_____

☐ **Drop Dependent due to:**
☐ Age ☐ Death ☐ Divorce ☐ Other Coverage Elsewhere
Date of Qualifying Event ___/___/_____

☐ **Name Change**
Former Name _____ New Name _____

☐ **Address Change** _____

☐ **Termination of Employment**
Date ___/___/_____

ENROLLMENT SELECTION

Select one for dental:

☐ **Member Only**	
☐ **Family**	

Are you and/or your dependent(s) covered by any other dental benefit program? ☐ Yes ☐ No
If "**Yes**," list the name of the carrier: _____

CONTINUED ON NEXT PAGE

DEPENDENTS

Indicate the names of all dependents to be insured or terminated under the Group/Employer Policy.

Add	Delete	First Name	Last Name (If different from Member)	Date of Birth MM/DD/YYYY	Relationship to Member	Dependent Status	Gender
☐	☐			/ /		☐Military ☐Disabled	
☐	☐			/ /		☐Military ☐Disabled	
☐	☐			/ /		☐Military ☐Disabled	
☐	☐			/ /		☐Military ☐Disabled	

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits.

Signature of Member	**Date** ___/___/_____