Enrollment/Eligibility Update

DELTA DENTAL®

PLAN TYPE:
(AS ESTABLISHED BETWEEN EMPLOYER AND DELTA DENTAL)

- ☐ DELTA DENTAL PPO
- ☐ DELTA DENTAL PPO - PLUS PREMIER
- ☐ DELTA DENTAL PPO - PLUS PREMIER "ELITE"
- ☐ DELTA DENTAL PREMIER
- ☐ DELTA DENTAL PREMIER - CHOICE
- ☐ DELTA DENTAL PPO - CHOICE
- ☐ DELTA DENTAL PPO - CHOICE ADVANTAGE
- ☐ DELTA DENTAL PPO - POINT OF SERVICE

www.DeltaDentalOK.org

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS, EXPLANATION OF CODES AND PRIVACY POLICY STATEMENT.

Employer: ______________________ GROUP#/SUBGROUP# ☐☐☐☐☐☐☐–☐☐☐☐ LOCATION CODE ☐☐☐☐☐

Subscriber Information: *(please complete in ink for enrollment/eligibility updates)*

SUBSCRIBER NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ M ☐ F | MARITAL STATUS ☐ M ☐ S

SUBSCRIBER SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ | BIRTH DATE | FULL-TIME HIRE DATE | COVERAGE EFFECTIVE DATE

STATUS: ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving Dep ☐ Other ______

ADDRESS

CITY | STATE | ZIP | CHECK HERE IF THIS IS A NEW ADDRESS ☐

E-MAIL: ____

Enrollment/Eligibility Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: ☐☐-☐☐-☐☐☐☐

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE

- ☐ NEW ENROLLMENT
- ☐ REINSTATEMENT
- ☐ OPEN ENROLLMENT
- ☐ COBRA ELECTION
- ☐ TERMINATION OF BENEFITS
- ☐ DECLINE
- ☐ TERMINATION OF EMPLOYMENT AS OF ______ -______-______

☐ CHANGE IN CURRENT ENROLLMENT STATUS FOR: ☐ SUBSCRIBER ☐ DEPENDENTS

REASON FOR CHANGE

- ☐ DIVORCE
- ☐ MARRIAGE
- ☐ NAME CHANGE
- ☐ LEGAL GUARDIANSHIP
- ☐ ADOPTION
- ☐ OTHER ______________________

GROUP TRANSFER-GROUP#/SUBGROUP# ☐☐☐☐☐☐☐–☐☐☐☐ TO: GROUP#/SUBGROUP# ☐☐☐☐☐☐☐–☐☐☐☐

Dependent Enrollment/Eligibility Update Information: *(please complete for spouse and/or dependent children for enrollment/eligibility update)*

SPOUSE NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ | BIRTH DATE

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ | BIRTH DATE | ☐ DISABLED*

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ | BIRTH DATE | ☐ DISABLED*

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ | BIRTH DATE | ☐ DISABLED*

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ | BIRTH DATE | ☐ DISABLED*

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma and acknowledge I have read the privacy policy detailed on the back of this form.

Subscriber's Signature: ______________________________ Date: ______________