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

EM BENEFITS

DELTA DENTAL®

ATTENTION: Eligibility Department | 234 Spring Lake Dr. | Itasca, Illinois 60143
FAX: (630) 773-8790 | PHONE: (630) 238-1900

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
☐ Male ☐ Female

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widowed
☐ Civil Union ☐ Domestic Partnership

Social Security Number or Alternate ID Number

Member Status
☐ Salaried ☐ Hourly ☐ Union ☐ Non-Union
☐ Member of Association and/or Member of Trust
☐ Hours Worked _____ ☐ Other _____

Mailing Address	City	State	ZIP

Phone Number
( )

Email Address

Name of Group	Group Number	Sublocation Number (if applicable)

Requested Effective Date of Coverage
___/___/_____

Date of Hire/Rehire
___/___/_____

I consent to receive Explanation of Benefits (EOBs) from Delta Dental of Illinois by Email. ☐ Yes ☐ No

I consent to receive policy and legally required communications from Delta Dental of Illinois by Email. ☐ Yes ☐ No

MEMBER/ EMPLOYEE/ DEPENDENT/ ADDITIONS/ TERMINATIONS/ CHANGES

Please check two of the options below.

☐ **Yes,** I want to enroll in this group dental benefit plan offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

☐ Delta Dental PPO/Delta Dental Premier If applicable: ☐ High Option ☐ Low Option

☐ DeltaCare (please complete the section below)

Dentist Name _____ Address _____ Facility Code _____

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

☐ **Yes,** I want to enroll in this group DeltaVision®* Coverage.

☐ **No,** I do not want to enroll in this group DeltaVision Coverage.

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** _____

☐ **DeltaCare Dentist Change** (please complete the section below)
Dentist Name _____ Address _____ Facility Code _____

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

ENROLLMENT SELECTION

Select one for dental:

☐ **Member Only**	☐ **Member Plus One Dependent**
☐ **Member Plus Spouse or Domestic Partner**	☐ **Member Plus Two or More Dependents**
☐ **Member Plus One Dependent Child**	☐ **Entire Family**
☐ **Member Plus Two or More Dependent Children**	☐ **Member Plus Child(ren)**

Is your spouse covered under another dental plan? ☐Yes ☐No
If "**Yes**," list the name of the carrier: _____
Please list your spouse's employer: _____

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

Select one for DeltaVision:

☐ **Member Only**	☐ **Member Plus One Dependent**
☐ **Member Plus Spouse or Domestic Partner**	☐ **Member Plus Two or More Dependents**
☐ **Member Plus One Dependent Child**	☐ **Entire Family**
☐ **Member Plus Two or More Dependent Children**	☐ **Member Plus Child(ren)**

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DEPENDENTS

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

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

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.

DISCLAIMER: The Spanish version of this form is provided only as a courtesy to the customer. The English version of this form will be the presiding version in any case of a dispute or complaint.

DESCARGO DE RESPONSABILIDAD: La versión en español de este documento se proporciona únicamente como cortesía para el cliente. La versión en inglés de este documento constituirá la versión predominante en el caso de alguna disputa o reclamación.

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. I understand that premiums for my coverage under the group policy will be remitted to Delta Dental of Illinois by my Group. If I must contribute to the premium for my coverage, I understand that arrangements for payroll deduction will be made by my Group.

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

**DeltaVision is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.*