LARGE GROUP DENTAL ENROLLMENT / CHANGE APPLICATION

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Social Security No.	Group Number		Effective Date ___/___/___
☐ New Applicant ☐ Late Enrollee	☐ Change of Coverage ☐ Name/Address Change	☐ Part-time to Full-time	Dept/EE Number

SECTION I	Name (First, Middle Initial, Last)	Telephone ( )	Date of Birth ___/___/___	☐ Male ☐ Female
Complete Address – Street	City	State / Zip	Status ☐ Single ☐ Married ☐ Other (specify)________	Hire Date ___/___/___

Employer Name & Location	Please check the coverage you are applying for: ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

I authorize Delta Dental of Iowa to notify me via e-mail to retrieve my Explanation of Benefits (EOB's) from the Delta Dental of Iowa's subscriber connection website @ www.deltadentalia.com. E-Mail: ____________________
Signature: ____________________

SECTION II ELIGIBLE DEPENDENTS

List eligible members of your family to be covered — First Name / Middle Initial / Last (if different)	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
Spouse		___/___/___	☐ M ☐ F		Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes

Other Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete: **Contract holder:**____________________

Name of other dental carrier	Policy Number	Effective Date ___/___/___	Contract type ☐ Single ☐ Family

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Drop Spouse/Child(ren) ☐ COBRA ☐ Terminating Benefits
☐ Other (explain) ____________________ Name of Affected Party ____________________ Date of Event _______

SECTION IV AGREEMENT and CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE	WAIVER OF COVERAGE
	☐ I waive dental coverage for my dependents and myself. (Please indicate reason) ☐ I (We) have coverage under another dental plan. ☐ I (We) do not wish to enroll
____________________ Employee Signature ___/___/___ Date	____________________ Employee Signature ___/___/___ Date