Ճ DELTA DENTAL[®]

Group Name: Effective Date: Group No: Sublocation/Division No: Section X: ENROLLMENT/CHANGE	IMPORTANT: Incomplete information will delay enrollment. Please print using a ballpoint pen, press firmly and print clearly.									
Section A: ENROLLMENT/CHANGE ADD dependent/spouse Coverage Change Reinstatement Open Enrollment TERMINATE dependent/spouse COBRA (Effective Date _//_) Cancel Coverage Open Enrollment ITERMINATE dependent/spouse COBRA (Effective Date _//) Reinstatement Open Enrollment ITERMINATE dependent/spouse COBRA (Effective Date _//) Reinstatement Open Enrollment Inderstand that I have been offered and have elected to decline coverage under my employer sponsored dental plan with Delta Dental at this time. Viii not be eligible to enroll until the next open enrollment period or in the event of a qualifying event during the coverage period. (Sign, date and complete first line of Section B.) Signature Date Section B.: EMPLOYEE INFORMATION Section Security Number Last Name First Name MI Social Security Number Mailing Address (#, Street, Apt) City State ZIP Home Telephone: () Date of Birth: / / Date of Hire: / / / Marriad Gender:: Male If married, will your spouse or dependents have coverage under another group dental plan on the date this plan becomes effective? No Yes Section C: COVERAGE Coverage Type Emp	Group Name:				Effective Date:					
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* Reason(s) for Change: Marriage Loss of other group coverage Divorce No longer dependent child Birth or adoption of child										
Death of spouse/dependent Other										
Date of Qualifying Event:										
Section E: AUTHORIZATION AND CERTIFICATION										
I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Virginia, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for underwriting purposes. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.										
I understand that my selection of coverage may be changed only during the open enrollment period of each year unless I experience a qualifying event listed under "Reasons for Change" in Section D. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may have violated state law. I certify that the information supplied by me on this form is accurate to the best of my knowledge. Under DeltaCare, in the event you fail to select a dentist in the DeltaCare network, you hereby authorize Delta Dental to select a dentist on your behalf so that your enrollment may be complete. You also authorize Delta Dental to change your selection, if you select a dentist not in Delta Dental of Virginia DeltaCare network or your dentist no longer participates with the Delta Dental of Virginia DeltaCare network.										
Signature: Date:										