

Enrollment/Change Form

DELTA DENTAL OF IDAHO
 PO Box 2870; Boise, ID 83701
 (208) 489-3582

Enrollment Form: Complete Sections I-III

Change Form: Complete Sections I-IV

I. EMPLOYEE INFORMATION (PLEASE PRINT)

Name (First)	(Middle Initial)	(Last)	Subscriber Number or SSN#	Date of Birth (mo/day/year)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Street or Route)			City, State, Zip		
Telephone #:	Date Employed Full-time:	# Hours Worked/Week:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
E-mail Address:				<small>By providing my email address, I agree to receive communications regarding my Policy electronically. This authorization may be revoked by calling Customer Service at (800) 356-7586.</small>	
Name of Employer:		For Employer Use	Group Number:	Effective Date:	

II. DEPENDENT INFORMATION (List all family members you wish to enroll)

Relationship to Applicant	SSN#	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/year)
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female

III. OTHER DENTAL COVERAGE (Medical coverage information is not required)

Do you or your dependents have **dental coverage** under another benefit plan? Yes No *If yes, please complete this section*

Name of Covered Person	Name of Covered Person's Place of Employment	Relationship to You	Date of Birth (mo/day/year)
Name of Dental Carrier		Dental Carrier's Address	Covered Person's Group #

Are you and all dependents listed above on the plan? Yes No *If No, list covered dependents.*

IV. CHANGE REQUESTS

Change current enrollment due to: Loss of previous coverage Marriage Divorce Birth Death Other _____ Date event occurred _____

Change my address to:	Change my email to:
Change my name from: _____	To: _____

I hereby apply for the group coverage for which I may be eligible, and I authorize the release of my records to Delta Dental of Idaho. I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.

Employee Signature: _____ Date: _____