

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM



PLEASE KEEP A COPY FOR YOUR FILES. *Please note that completing this form does not guarantee coverage.*

ALL GROUPS MUST COMPLETE THIS SECTION Note: Incomplete forms will be returned.

Delta Dental Group Number _____ Sublocation Number _____ Salaried Hourly
 Effective Date _____ Date of Hire _____ OR Date of Rehire _____ Non-Union Union
 Name of Employer _____ Location/Department _____ Other _____
 Group Contact _____ Phone _____ Group Contact Email _____

EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

Yes, I want to enroll in the dental and/or vision benefit plan(s) 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 DHMO (please complete the section below)
 Dentist Name _____ Address _____ Facility Code _____
 DeltaCare DHMO Dentist Change (please complete the section below)
 Dentist Name _____ Address _____ Facility Code _____
 DeltaVision®

No, I do not want to enroll in the dental benefit plan.
 No, I do not want to enroll in the vision benefit plan. *(If you are declining, please write your name below and sign at the bottom of this form.)*

Social Security Number _____ Employee's Name _____
First Name MI Last Name

Alternate ID # _____ # Hours Worked _____ Job Title _____

Mailing Address _____
Street City State Zip

Email Address _____ Phone Number _____

Marital Status: S M Other Date of Birth ____/____/____ Male Female

REASON FOR SUBMITTING THIS FORM

Initial or Open Enrollment COBRA COBRA End Date ____/____/____ Retiree
 Reinstatement due to: Rehire Loss of Other Coverage Other _____
 Add Dependent (list below) due to:
 Birth Adoption Marriage Loss of Other Coverage Legal Guardianship Disabled Dependent
 Military Dependent Other _____ Date of Qualifying Event ____/____/____
 Drop Dependent (list below) due to:
 Age Death Divorce Other Coverage Elsewhere Date of Qualifying Event ____/____/____
 Termination of Employment Date ____/____/____ Covered Under Spouse Date ____/____/____
 Name Change (Former Name _____) Address Change

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/dd/yyyy)	SEX (M or F)
<input type="checkbox"/>	<input type="checkbox"/>	1. Spouse:			
<input type="checkbox"/>	<input type="checkbox"/>	2. Child:			
<input type="checkbox"/>	<input type="checkbox"/>	3.			
<input type="checkbox"/>	<input type="checkbox"/>	4.			
<input type="checkbox"/>	<input type="checkbox"/>	5.			

DENTAL COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family

Is spouse covered under another dental plan? Yes No Other Carrier Name _____
 Are dependents covered by spouse's plan? Yes No Spouse's Carrier _____
 Spouse's Employer _____

VISION COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family

I am requesting the coverage(s) I have selected above for which I am eligible under the contract issued by Delta Dental of Illinois for dental coverage and/or by TruAssure Insurance Company for vision coverage. I agree to continue membership in this program until the next open enrollment period. I certify that all the information stated on this form is complete and true to the best of my knowledge and Delta Dental of Illinois/TruAssure Insurance Company believing it to be true shall rely and act upon it accordingly. I authorize my employer/group to deduct from my pay and remit any required contributions for the cost of the selected coverage. This authorization is to remain in effect until Delta Dental of Illinois/TruAssure Insurance Company is notified in writing to the contrary.

Signature of Applicant _____ Date _____

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

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 369-0384 • Email eligibility@deltadentalil.com

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