

Delta Dental PPO      Delta Dental Premier

Delta Dental Premier, Delta Dental PPO and Delta Dental PPO Plus Premier are offered by Delta Dental of Kentucky, Inc.

DeltaCare is offered by Dental Choice, Inc.

OPEN ENROLLMENT      NEW ENROLLMENT      STATUS CHANGE      COBRA \_\_\_\_\_

Complete Status Change information below.

COBRA effective date.

Social Security Number	Name – Last	First	MI	Birthdate / /
Home Address – Number and Street	City	State	Zip	Group Number
Sex (Circle one) <b>M or F</b>	Employer Name	Hire Date Required / /		Section Number

**Check the type of contract and list all members:**

Single      Employee and Spouse      Employee and child      Employee and children      Family

**MEMBERS** Please list all dependents below, if applicable. If additional space is required, attach a list to this form.

Last	First	MI	Date of Birth			Sex		FULL-TIME STUDENT		STATUS CHANGES ONLY (Circle one)	Does member have other dental coverage? If so, give insurance company name and telephone number, policyholder's name and identification number.
			MO	DAY	YR	M	F	YES*	NO		
Spouse										ADD DELETE	
Dependent										ADD DELETE	
Dependent										ADD DELETE	
Dependent										ADD DELETE	
Dependent										ADD DELETE	

**\*Dependent children coverage requiring student verification once they have turned age 19 must submit proof of full-time school enrollment. A signed Delta Dental affidavit is acceptable.**

**STATUS CHANGES ONLY** (Complete all that apply. Qualifying event required.)

Indicate new contract type below and add or delete dependents in MEMBERS grid above:

Single      Employee and Spouse      Employee and child      Employee and children      Family

Qualifying Event: \_\_\_\_\_ QE Effective Date: \_\_\_\_\_

Terminate Subscriber's Contract as of \_\_\_\_\_

Name Change: Previous Name: \_\_\_\_\_ New Name: \_\_\_\_\_

Address Change: \_\_\_\_\_

**SHADED AREA FOR OFFICE USE ONLY**

Effective Date	Process Date	Processed By
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**READ THE PROVISIONS ON THE BACK OF THIS ENROLLMENT FORM CAREFULLY BEFORE SIGNING.  
PLEASE REVIEW YOUR ENROLLMENT FORM FOR ERRORS OR OMISSIONS.**

I acknowledge I have read the provisions on the back of this enrollment form and I expressly accept such provisions as a condition of coverage. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Dental Choice (DeltaCare) or Delta Dental (Delta Dental Premier and Delta Dental PPO) in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). If accepted, this form, the member certificate, the identification card, and the group contract will constitute the contract.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please make a copy for your records and return original to your Human Resources Director.**