



Delta Dental Plan of Kansas

# Enrollment/Change Form

### CHECK ONE:

- New Application for Coverage
- Change Authorization
- Waiver of Coverage (complete Section 6 only)

## Section 1—Employee Information (Please Type or Print Legibly):

Social Security Number:	Group Number:	Group Name (Please do not abbreviate):			
Location Number/Code:	Employee Name (First, Middle Initial, Last):			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:	City:	State:	Zip Code:	Birth Date (M/D/Y):	
<input type="checkbox"/> Single <input type="checkbox"/> Married	Hire Date (M/D/Y):	Eligibility Date (M/D/Y):	Type of Medical Coverage:	Medical Carrier and Address:	
			<input type="checkbox"/> Single <input type="checkbox"/> Family		

## Section 2—Other Insurance Information (Complete ONLY if requesting coverage for dependent[s]):

Does your spouse have dental/medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide spouse's Social Security # _____ Spouse's employer: _____	Dental Carrier: _____ Address: _____ Medical Carrier: _____ Address: _____
Are your dependents covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are your dependents covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Section 3—Dependent Information (List ONLY eligible family members to be enrolled or affected by change):

	Add/ Delete	First Name, Middle Initial, Last Name (if different)		Birth Date (M/D/Y)
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>NOTE:</b> If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits: _____				
Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Male <input type="checkbox"/> Female	

## Section 4—Changes (Please mark all appropriate boxes that apply to change(s) you wish to make):

**ALL CHANGES MUST BE MADE WITHIN 30 DAYS.**

Name Change: From: \_\_\_\_\_ To: \_\_\_\_\_  Marriage  Divorce  
 Adoption/Legal custody of child  
 Other: \_\_\_\_\_

DATE OF EVENT: \_\_\_\_\_

## Section 5—Signature/Authorization for Enrollment/Change(s):

I hereby apply for the group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental Plan of Kansas, Inc.

Authorization/Signature for Enrollment/Change(s): \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION 6—WAIVER OF COVERAGE (Complete ONLY if you or your family are not enrolling for benefits):

This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer, and I have decided:

Not to apply for dental coverage for myself or my family because:  Covered by spouse.  Other \_\_\_\_\_  
 I wish to apply for dental coverage for myself only. I have decided not to apply for dental coverage for my family because:  
 My spouse and/or children are covered by other group dental insurance.  Other \_\_\_\_\_

I understand that, in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental Plan of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name (First, Middle Initial, Last): \_\_\_\_\_ Social Security #: \_\_\_\_\_