

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)

| | | | |
|------------------------------------|------------------------------|-------------------------|---|
| Add <input type="checkbox"/> | Social Security / ID Number: | Group Number: 6002-1 | Employer/Group Name: (Please do not abbreviate) Greenbush Health |
| Terminate <input type="checkbox"/> | | | |

| | |
|--|---------------------------------|
| Employee Name: (First, Middle Initial, Last) | Male <input type="checkbox"/> |
| | Female <input type="checkbox"/> |

| | | | | |
|---------------|-------|--------|-----------|------------------------|
| Home Address: | City: | State: | Zip Code: | Birth Date: (mm/dd/yy) |
|---------------|-------|--------|-----------|------------------------|

| | | | | |
|----------------------------------|-----------------------|----------------------------|--|------------------------------|
| Single <input type="checkbox"/> | Hire Date: (mm/dd/yy) | Effective Date: (mm/dd/yy) | Type of Medical Coverage: Single <input type="checkbox"/> Family <input type="checkbox"/> | Medical Carrier and Address: |
| Married <input type="checkbox"/> | | | | |

Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)

| Action: | Effective Date: | Spouse Name: (First, Middle Initial, Last) | Male | Female | Birth Date: |
|------------------------------------|-----------------|--|--------------------------|--------------------------|-------------|
| Add <input type="checkbox"/> | (mm/dd/yy) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Terminate <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | |

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:

| Action: | Effective Date: | Dependent Name: (First, Middle Initial) (Last Name, if different) | Male | Female | Birth Date: |
|------------------------------------|-----------------|---|--------------------------|--------------------------|-------------|
| Add <input type="checkbox"/> | (mm/dd/yy) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Terminate <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Add <input type="checkbox"/> | (mm/dd/yy) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Terminate <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Add <input type="checkbox"/> | (mm/dd/yy) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Terminate <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Add <input type="checkbox"/> | (mm/dd/yy) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Terminate <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | |

Section 3 OTHER INSURANCE INFORMATION: (Complete ONLY if requesting coverage for dependent[s])

| | | | |
|---|--|--|------------------|
| | Spouse | Children | |
| Are your dependents covered by another <u>dental</u> plan? | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> | Dental Carrier: |
| Are your dependents covered by another <u>medical</u> plan? | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> | Address: |
| If YES, please provide spouse's Social Security #: _____ | | | Medical Carrier: |
| Spouse's employer: _____ | | | Address: |

Section 4 CHANGES: (Please mark all appropriate boxes that apply to change[s] you wish to make)

DELTA DENTAL MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT

DATE of EVENT: _____

Name Change: From: _____ To: _____

Marriage: Divorce: Other:

Adoption/Legal Custody of Child:

Section 5 SIGNATURE/AUTHORIZATION:

I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental 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 that I:

Do not want dental coverage for myself because: _____

Do not want dental coverage for my spouse and/or my children.

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 of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage: _____ Date: _____

Printed-Employee Name: (First, Middle Initial, Last) _____ Social Security #: _____