



SMALL BUSINESS PROGRAM ENROLLMENT/CHANGE FORM



Enrollment guidelines (except for PPO Vol):

1. Eligible employees electing coverage for themselves must enroll following completion of their eligibility period. Employees who do not enroll **cannot enroll at a later time** unless they show proof of loss of prior coverage under another dental program.
2. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage under another dental program.

Policy Information

Company/Group Name	Delta Dental plan (check one) ☐ Delta Dental PPO sm ☐ DeltaCare [®] USA	Employer #
--------------------	--	------------

Reasons For Addition/Change (check one)

☐ New hire	☐ Part-time to full-time (give date of full-time start date)	☐ Dependent change (provide reason & date of qualifying event)
☐ Loss of coverage (provide proof — letter from prior carrier/employer)	☐ Fed-COBRA enrollment (provide termination date)	☐ Name or SS # correction (provide old and new number or SS #)
☐ Domestic Partner	☐ Rehire (note rehire date) _____	☐ Reinstatement
☐ Other (please explain) _____		

Comments:	Effective date:
-----------	-----------------

Enrollee Information

Enrollee name (Last name, first name)	Social security number	Gender ☐ M ☐ F	Date of birth	Date of hire
Mailing address	City	State	ZIP	Phone

Dependents to be Enrolled or Deleted

Spouse/domestic partner name (last, first)	☐ Add ☐ Term	Gender ☐ M ☐ F	Date of birth	
Child name (Last, First)	☐ Add ☐ Term	Gender ☐ M ☐ F	Date of birth	If 19 years or older check one: ☐ Full-time student under 25* ☐ Disabled
	☐ Add ☐ Term	☐ M ☐ F		☐ Full-time student under 25* ☐ Disabled
	☐ Add ☐ Term	☐ M ☐ F		☐ Full-time student under 25* ☐ Disabled
	☐ Add ☐ Term	☐ M ☐ F		☐ Full-time student under 25* ☐ Disabled <i>*Provide proof of full-time student status</i>

DeltaCare USA Enrollees Must Fill Out This Section

Provider choice: Dental office ID #	Dental office city	Dental office name
-------------------------------------	--------------------	--------------------

Signature

Enrollee signature	Date
--------------------	------

This form must be received no later than the 25th of the month prior to the desired effective date. Please allow 5 days to process.