

ENROLLMENT/CHANGE FORM FOR SMALL BUSINESSES

Enrollment guidelines:

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 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.

Delta Group Name Small Businesses	Delta Group Number	Name of Your Employer	Employer Number
Name Last _____ First _____ M.I. _____		Social Security Number IMPORTANT — PRINT VERY CLEARLY _____ — _____	
Address _____		City _____	State _____ ZIP _____

A. Complete this section for new enrollment or change of status

Action requested <input type="checkbox"/> New enrollment <input type="checkbox"/> Change in enrollment <input type="checkbox"/> Rehire <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> SSN Correction	Date Employed ____ / ____ / ____ <small>Month Day Year</small>	Birthdate ____ / ____ / ____ <small>Month Day Year</small>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	FOR OFFICE USE ONLY Effective date of coverage _____
<input type="checkbox"/> COBRA Enrollment I understand that I may be required by the employer to pay for COBRA benefits. Note: If Dependent is enrolling under own social security number, the original Enrollee's social security number must be supplied. _____ Qualifying Date ____ / ____ / ____ <small>Month Day Year</small> <small>Benefits previously received under social security number (Enrollee ID Number)</small>				

B. Complete this section for changes to existing enrollment (Complete all sections that apply)

<input type="checkbox"/> Name change <input type="checkbox"/> Add/delete dependent <input type="checkbox"/> Add/delete domestic partner Effective date of change ____ / ____ / ____
Reason for change _____

C. Complete this section for new dependent enrollment or to add or delete dependents

Spouse/Domestic Partner Name	Add / Delete	Sex	Birthdate	Date of Marriage	
Last (if different) _____ First _____		M F	Month Day Year	Month Day Year	
Child Name	Add / Delete	Sex	Birthdate	If child is 19 years or older	
Last (if different) _____ First _____		M F	Month Day Year	Full-time Student?*	Disabled?
				<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If yes, please provide proof of full-time student status

D. Signature (Form must be signed to be processed)

I understand that I may be required to contribute up to 25% of the cost for my coverage. Additionally, I may be required to contribute up to 50% for coverage of my dependent(s). (Exception — See COBRA enrollment.) I agree to continue membership in this program during employment and while the program is in force, I agree to comply with the terms of the contract.

Employee Signature _____ Date _____

Form must be received no later than the 25th of the month prior to the desired effective date. PLEASE ALLOW AT LEAST 5 DAYS TO PROCESS.