DELTA DENTAL

ENROLLMENT / CHANGE APPLICATION

Delta Dental of Iowa
P.O. Box 788
Ankeny, Iowa 50021-0788
www.deltadentalia.com
1-877-983-3582

Social Security No.	Group Number	Effective Date ___/___/___
☐ New Applicant ☐ Change of Coverage ☐ Late Enrollee ☐ Name/Address Change	Department Number	Employee Number

SECTION I

Name (First, Middle Initial, Last)	Telephone ( )	Date of Birth ___/___/___	☐ Male ☐ Female
Complete Address – Street City State Zip	Status ☐ Single ☐ Married ☐ Other (specify) ________	Hire Date ___/___/___	
Employer Name & Location	Please check the coverage you are applying for: ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)		

SECTION II ELIGIBLE DEPENDENTS

List eligible members of your family to be covered First Name Middle Initial Last (if different)	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
Spouse		___/___/___	☐ M ☐ F		Disabled? ☐ Yes	☐ No ☐ Yes
Dependent		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	Disabled? ☐ Yes	☐ No ☐ Yes
Dependent		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	Disabled? ☐ Yes	☐ No ☐ Yes
Dependent		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	Disabled? ☐ Yes	☐ No ☐ Yes
Dependent		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	Disabled? ☐ Yes	☐ No ☐ Yes
Dependent		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	Disabled? ☐ Yes	☐ No ☐ Yes

Other Dental Coverage – If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete: **Contract holder:** ____________________

____________________ ____________________ ___/___/___ ☐ Single ☐ Family
Name of other dental carrier **Policy Number** **Effective Date** **Contract type**

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Dependents** ☐ **COBRA** ☐ **Terminating Benefits**

☐ **Other (explain)** ____________________ **Name of Affected Party** ____________________ **Date of Event** ________

SECTION IV AGREEMENT and CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE	WAIVER OF COVERAGE
	☐ I waive dental coverage for my dependents and myself. (Please indicate reason) ☐ I (We) have coverage under another dental plan. ☐ I (We) do not wish to enroll.
____________________ Employee Signature ___/___/___ Date	____________________ Employee Signature ___/___/___ Date

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