



ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
 P.O. Box 15965
 North Little Rock, AR 72231
 Fax: (501) 992-1890

New Enrollment Status Change* Cobra Termination

Effective Date Month Day Year	Group No: _____ Group Name: _____	Social Security Number - - -
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LAST NAME: _____ FIRST: _____ MI _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: () _____

Date of Birth	Marital Status	Sex	Date of Hire
MM / DD / YY	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female	MM DD YY

TYPE OF COVERAGE SELECTED	*Please check the box(es) next to the reason(s) for your change:
<p>*Type (check one):</p> <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family	<input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> Change Coverage <input type="checkbox"/> Remove Dependent(s) listed below <input type="checkbox"/> Address Change Only <input type="checkbox"/> Name Change Reason(s) for Change: Date of event _____ <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of spouse's coverage <input type="checkbox"/> Divorce <input type="checkbox"/> No longer dependent child <input type="checkbox"/> Birth or adoption of child <input type="checkbox"/> Death of dependent <input type="checkbox"/> Other _____ <input type="checkbox"/> COBRA effective date

LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY A CHANGE					
Last (if different)	First	MI	Relationship	Sex M/F	Birthdate Month/Day/Year
1. <input type="checkbox"/> Add <input type="checkbox"/> Remove					
2. <input type="checkbox"/> Add <input type="checkbox"/> Remove					
3. <input type="checkbox"/> Add <input type="checkbox"/> Remove					
4. <input type="checkbox"/> Add <input type="checkbox"/> Remove					
5. <input type="checkbox"/> Add <input type="checkbox"/> Remove					
6. <input type="checkbox"/> Add <input type="checkbox"/> Remove					

AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have been offered the opportunity to enroll in the dental program through Delta Dental; however, I waive coverage at this time.
 I authorize payroll deductions.

Signature: _____ Date: _____