DENTAL ENROLLMENT FORM

DO NOT WRITE IN THIS BOX
Delta Dental Group Number: 10981
Effective Date: _____
Date of Hire: _____
Name of Employer: County of Champaign
Group Contact: DeShonna Matthew Phone: 217-384-3776 Email: dmatthew@champaigncountyil.gov

Plan choice: Choose one:

Employee Name: _____

Social Security Number: _____

Mailing Address: _____
Street Address/P.O. Box, City, State, Zipcode

Phone Number: _____

Marital Status: _____ Date of Birth _____ Sex: _____

Reason for submitting this form:

☐ Initial Enrollment ☐ Open Enrollment

☐ Add Dependent due to: Choose One:

Date of Qualifying Event _____

☐ Drop Dependent due to: Choose One:

Date of Qualifying Event _____

List Dependents to be covered:

Add or Delete		First Name, Last Name if different	Date of Birth/Gender
No Change	spouse		
No Change	child		
No Change	child		
No Change	child		
No Change	child		
No Change	child		

Dental Coverage Desired: Choose One:

_____

Signature Date

Return completed form to DeShonna Matthew, Administrative Services Department dmatthew@champaigncountyil.gov