

# ENROLLMENT/CHANGE OF STATUS/WAIVER FORM



PLEASE KEEP A COPY FOR YOUR FILES. Please note that completing this form does not guarantee coverage.

## ALL GROUPS MUST COMPLETE THIS SECTION Note: Incomplete forms will be returned.

Delta Dental Group Number \_\_\_\_\_ Sublocation Number \_\_\_\_\_  Salaried  Hourly  
Effective Date \_\_\_\_\_ Date of Hire \_\_\_\_\_ OR Date of Rehire \_\_\_\_\_  Non-Union  Union  
Name of Employer \_\_\_\_\_ Location/Department \_\_\_\_\_  Other \_\_\_\_\_  
Group Contact \_\_\_\_\_ Phone \_\_\_\_\_ Group Contact Email \_\_\_\_\_

## EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

**Yes**, I want to enroll in the dental and/or vision benefit plan(s) offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

Delta Dental PPO/Delta Dental Premier If applicable:  High Option  Low Option

DeltaCare DHMO (please complete the section below)

Dentist Name \_\_\_\_\_ Address \_\_\_\_\_ Facility Code \_\_\_\_\_

DeltaCare DHMO Dentist Change (please complete the section below)

Dentist Name \_\_\_\_\_ Address \_\_\_\_\_ Facility Code \_\_\_\_\_

DeltaVision®

**No**, I do not want to enroll in the dental benefit plan.

**No**, I do not want to enroll in the vision benefit plan. (If you are declining, please write your name below and sign at the bottom of this form.)

Social Security Number \_\_\_\_\_ Employee's Name \_\_\_\_\_

Alternate ID # \_\_\_\_\_ # Hours Worked \_\_\_\_\_ Job Title \_\_\_\_\_

Mailing Address \_\_\_\_\_

Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Marital Status:  S  M  Other Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

## REASON FOR SUBMITTING THIS FORM

Initial or Open Enrollment  COBRA COBRA End Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Retiree

Reinstatement due to:  Rehire  Loss of Other Coverage  Other \_\_\_\_\_

Add Dependent (list below) due to:

Birth  Adoption  Marriage  Loss of Other Coverage  Legal Guardianship  Disabled Dependent

Military Dependent  Other \_\_\_\_\_ Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

Drop Dependent (list below) due to:

Age  Death  Divorce  Other Coverage Elsewhere Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

Termination of Employment Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Covered Under Spouse Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name Change (Former Name \_\_\_\_\_)  Address Change

## PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/dd/yyyy)	SEX (M or F)
<input type="checkbox"/>	<input type="checkbox"/>	1. Spouse:			
<input type="checkbox"/>	<input type="checkbox"/>	2. Child:			
<input type="checkbox"/>	<input type="checkbox"/>	3.			
<input type="checkbox"/>	<input type="checkbox"/>	4.			
<input type="checkbox"/>	<input type="checkbox"/>	5.			

## DENTAL COVERAGE DESIRED

Employee Only  Employee & Spouse  Employee & One Child  Employee & Children  Entire Family

Is spouse covered under another dental plan?  Yes  No Other Carrier Name \_\_\_\_\_

Are dependents covered by spouse's plan?  Yes  No Spouse's Carrier \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

## VISION COVERAGE DESIRED

Employee Only  Employee & Spouse  Employee & One Child  Employee & Children  Entire Family

I am requesting the coverage(s) I have selected above for which I am eligible under the contract issued by Delta Dental of Illinois for dental coverage and/or by TruAssure Insurance Company for vision coverage. I agree to continue membership in this program until the next open enrollment period. I certify that all the information stated on this form is complete and true to the best of my knowledge and Delta Dental of Illinois/TruAssure Insurance Company believing it to be true shall rely and act upon it accordingly. I authorize my employer/group to deduct from my pay and remit any required contributions for the cost of the selected coverage. This authorization is to remain in effect until Delta Dental of Illinois/TruAssure Insurance Company is notified in writing to the contrary.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

\*Please Note: DeltaVision® is provided by TruAssure Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 369-0384 • Email [eligibility@deltadentalil.com](mailto:eligibility@deltadentalil.com)

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