Delta Dental of Illinois Enrollment/Change of Status Form for Group/Employer Dental Policy

ATTENTION: Eligibility Department | P.O. Box 3384 | Lisle, Illinois 60532
PHONE: (800) 323-1743

Please type or print in black ink and complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

MEMBER

Last Name	First Name	Middle Initial	Date of Birth
			___/___/_____

Gender	Marital Status	Social Security Number or Alternate ID Number
	☐Married ☐Single ☐Divorced ☐Widowed ☐Civil Union ☐Domestic Partnership	

Member Status
☐Salaried ☐Hourly ☐Non-Union ☐Other _____

Mailing Address	City	State	ZIP

Phone Number ( )	Email Address

Name of Group/Employer	Group/Employer Number	Sublocation Number (if applicable)

Requested Effective Date of Coverage	Date of Hire/Rehire
___/___/_____	___/___/_____

I consent to receive Explanation of Benefits (EOBs) from Delta Dental of Illinois by Email. ☐Yes ☐No

I consent to receive policy and legally required communications from Delta Dental of Illinois by Email. ☐Yes ☐No

MEMBER/DEPENDENT ADDITIONS/CHANGES

Please check two of the options below.

☐ **Yes,** I want to enroll in this group/employer dental benefit plan offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

☐ Delta Dental PPO℠/Delta Dental Premier®

☐ DeltaCare (please complete the section below)

Dentist Name _____ Address _____ Facility Code _____

☐ **No,** I do not want to enroll in this group/employer dental benefit plan offered by Delta Dental of Illinois.

☐ **Yes,** I want to enroll in this group/employer DeltaVision®* Coverage.

☐ **No,** I do not want to enroll in this group/employer DeltaVision Coverage.

CONTINUED ON NEXT PAGE

REASON(S) FOR SUBMITTING THIS FORM

☐ **Initial or Open Enrollment**

☐ **COBRA**
End Date ___/___/_____

☐ **Retiree**

☐ **Reinstatement due to:**
☐Rehire ☐Loss of Other Coverage ☐Other _____

☐ **Add Dependent due to:**
☐Birth ☐ Adoption/Placement for Adoption ☐Marriage ☐ Domestic Partnership
☐Civil Union ☐Legal Guardianship ☐Loss of Other Coverage
☐Dependent Child with Disability ☐Military Dependent ☐Court Order ☐Other _____
Date of Qualifying Event ___/___/_____

☐ **Drop Dependent due to:**
☐ Age ☐Death ☐Divorce ☐Other Coverage Elsewhere
Date of Qualifying Event ___/___/_____

☐ **Name Change**
Former Name _____ New Name _____

☐ **Address Change** _____

☐ **DeltaCare Dentist Change**

☐ **Termination of Employment**
Date ___/___/_____

ENROLLMENT SELECTION

Select one for dental:

☐ **Member Only**	☐ **Member Plus One Dependent**
☐ **Family**	☐ **Member Plus Child(ren)**

Are you and/or your dependent(s) covered by any other dental benefit program? ☐Yes ☐No
If "**Yes**," list the name of the carrier: _____

Select one for DeltaVision:

☐ **Member Only**	☐ **Member Plus One Dependent**
☐ **Family**	☐ **Member Plus Child(ren)**

CONTINUED ON NEXT PAGE

DEPENDENTS

Indicate the names of all dependents to be insured or terminated under the Group/Employer Policy.

Add	Delete	First Name	Last Name (If different from Member)	Date of Birth MM/DD/YYYY	Relationship to Member	Dependent Status	Gender
☐	☐			/ /		☐ Military ☐ Disabled	
☐	☐			/ /		☐ Military ☐ Disabled	
☐	☐			/ /		☐ Military ☐ Disabled	
☐	☐			/ /		☐ Military ☐ Disabled	

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits.

Signature of Member	**Date** ___/___/_____

**DeltaVision is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.*