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 10713 Sublocation Number 00002

Effective Date ______ Date of Hire ______ OR Date of Rehire ______

Name of Employer SIHWIT-C. USD Location/Department ______

Group Contact Valerie Rodgers Phone 618-997-9201 Group Contact Email ______

☐ Salaried ☐ Hourly
☐ Non-Union ☐ Union
☐ Other ______

EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

☐ **Yes,** I want to enroll in the dental 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

☐ **No,** I do not want to enroll in the dental 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 ______ (First Name, MI, Last Name)

Alternate ID # ______ # Hours Worked ______ Job Title ______

Mailing Address ______ (Street, City, State, Zip)

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)
☐	☐	1. Spouse:			
☐	☐	2. Child:			
☐	☐	3.			
☐	☐	4.			
☐	☐	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 ______

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 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 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 Insurance Company is notified in writing to the contrary.

Signature of Applicant ______ Date ______

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