



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partnership			Social Security Number or Alternate ID Number	
Member Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Union <input type="checkbox"/> 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 PPOSM/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
				__/__/____		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female
				__/__/____		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female
				__/__/____		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female
				__/__/____		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female

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