DELTA DENTAL

(Please keep a copy for your records)
Revised 9-2007

Enrollment/Change Form

Check One:
- ☐ New Application for Coverage
- ☐ Change Authorization
- ☐ Waiver of Coverage (complete Section (6) ONLY)

Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)

Add ☐ Terminate ☐	Social Security / ID Number:	Group Number: 53273	Employer/Group Name: (Please do not abbreviate) USD 495 - Ft. Larned

Employee Name: (First, Middle Initial, Last) — Male ☐ Female ☐

Home Address:	City:	State:	Zip Code:	Birth Date: (mm/dd/yy)

Single ☐ Married ☐	Hire Date: (mm/dd/yy)	Effective Date: (mm/dd/yy)	Type of Medical Coverage: Single ☐ Family ☐	Medical Carrier and Address:

Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)

Action:	Effective Date:	**Spouse** Name: (First, Middle Initial, Last)		Birth Date:
Add ☐ Terminate ☐	(mm/dd/yy)		Male ☐ Female ☐	

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:

Action:	Effective Date:	**Dependent** Name: (First, Middle Initial) (Last Name, if different)	Male	Female	Birth Date:
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	

Section 3 OTHER INSURANCE INFORMATION: (Complete ONLY if requesting coverage for dependent[s])

	Spouse	Children
Are your dependents covered by another dental plan?	◯Yes ◯No	◯Yes ◯No
Are your dependents covered by another medical plan?	◯Yes ◯No	◯Yes ◯No

If YES, please provide spouse's Social Security #:_____

Spouse's employer:_____

Dental Carrier:
Address:
Medical Carrier:
Address:

Section 4 CHANGES: (Please mark all appropriate boxes that apply to change[s] you wish to make)

DELTA DENTAL OF KANSAS MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT

DATE OF EVENT:_____

☐ Name Change: From:_____ To:_____

☐ Adoption/Legal Custody of Child

☐ Marriage ☐ Divorce ☐ Other:

Section 5 SIGNATURE / AUTHORIZATION:

I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.

Authorization/Signature for Enrollment/Change[s]:_____ Date:_____

Section 6 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)

This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer, and I have decided that I:

☐ **Do not** want dental coverage for myself because:_____.

☐ **Do not** want dental coverage for my spouse and/or my children.

I understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage:_____ Date:_____

Printed-Employee Name: (First, Middle Initial, Last) _____ Social Security #:_____