



ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
E-mail: eligibility@ddpar.com
Fax (501) 992-1890

- New Enrollment Status Change Address Change Termination
- Dental Only Vision Only Dental/Vision Cobra

Effective Date:

Month	Day	Year

 Group Number: _____
Group Name: _____

Social Security Number:

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Subscriber's Identifier (if applicable): _____

LAST NAME: _____ FIRST: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

Date of Birth: MM / DD / YY Marital Status: Single Married
Sex: Male Female Date of Hire: MM / DD / YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code." Enter P for pregnant, D for diabetes, and H for Heart Disease)

Pregnancy - Expected due date _____
 Diabetes - Date of onset _____
 Heart Disease - Date of onset _____

1. COVERAGE CHANGES * Please check the box(es) next to the reason(s) for your change

<p>Type coverage selected (choose one)</p> <table style="width: 100%;"> <tr> <td style="width: 50%;"> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family </td> <td style="width: 50%;"> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family </td> </tr> </table>	Dental <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family	Vision <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family	<input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> Remove Dependent(s) listed below <input type="checkbox"/> Name Change <input type="checkbox"/> Late Entrance (employee) Reason(s) for Change: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth or adoption of child <input type="checkbox"/> Full Time Student <input type="checkbox"/> Handicapped <input type="checkbox"/> Other _____ <input type="checkbox"/> COBRA effective date _____	<input type="checkbox"/> Change Coverage <input type="checkbox"/> Address Change only <input type="checkbox"/> Qualifying event <input type="checkbox"/> Late Entrance (dependent) Date of event _____ <input type="checkbox"/> Loss of spouse's coverage <input type="checkbox"/> No longer dependent child <input type="checkbox"/> Death of dependent <input type="checkbox"/> No longer Full Time Student
Dental <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family	Vision <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family			

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time.**
- I authorize payroll deductions.

Signature: _____ Date: _____