



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 ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Civil Union ☐ Domestic Partnership			Social Security Number or Alternate ID Number	
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 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 ☐ NoIf "**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	☐ Male ☐ Female
☐	☐			___/___/___		☐ Military ☐ Disabled	☐ Male ☐ Female
☐	☐			___/___/___		☐ Military ☐ Disabled	☐ Male ☐ Female
☐	☐			___/___/___		☐ Military ☐ Disabled	☐ Male ☐ 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

___/___/___

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