DELTA DENTAL

Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-521-2651
Fax: 770-641-5393

Please select one: ☐ 12 Mo EEs High Plan (div 00001) ☐ 9 Mo EEs High Plan (div 00002)
☐ 12 Mo EEs Low Plan (div 00003) ☐ 9 Mo EEs Low Plan (div 00004)

For Employer Use Only

Effective Date	Group No
/ /	25-16037
Full Time Hire Date	Sublocation
/ /	

Check One (**Enrollees can change plans only during open enrollment.)

- ☑ New Hire
- ☐ Open Enrollment
- ☐ Change Dental Plans**
- ☐ COBRA
- ☐ Add/Delete Dependent
- ☐ Terminate Employee Coverage
- ☐ Spouse Employment Change
- ☐ Marital Change
- ☐ Other _____

Indicate qualifying date: (Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Widowed/Surviving Dependent
- ☐ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Jackson State University Location

Marital Status: Single ■ Married ☐ Gender: Male ☐ Female ■ Phone # ( ) —

Do you have dependent children? Yes ■ No ☐ Are you or your dependents covered under another dental plan? Yes ■ No ☐

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth: (Month) (Day) (Year)
Spouse:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

☐ I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____