



# ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas  
 P.O. Box 15965  
 North Little Rock, AR 72231  
 Fax (501) 992-1890

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

Effective Date			Group Number: _____		Social Security Number		
Month	Day	Year	Group Name: _____		Subscriber's Identifier (if applicable)		

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER: (      ) \_\_\_\_\_

**Other Coverage Info:**  
 Do you have current dental coverage?    Yes    No

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

Is this coverage intended to replace your current dental coverage?       Yes    No

What is the name of your current carrier? \_\_\_\_\_

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

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

**LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE**

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

**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.

**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: \_\_\_\_\_ DDVIS06A-06