DELTA DENTAL®
Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

PMI DENTAL HEALTH PLAN

For Employer Use Only	
Effective Date / /	Group No.
Full Time Hire Date	Sublocation

Select a Program: Delta Dental ❑ DeltaCare* ❑ (Not available in all areas)

*DeltaCare is underwritten by Delta Dental Insurance Company and is administered by Private Medical-Care, Incorporated (PMI).

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)

- ❑ **Delta Dental** - CANCEL
- ❑ **DeltaCare** - CANCEL

Delta Dental - 1-800-521-2651
DeltaCare - 1-800-422-4234

Primary Enrollee Information

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

Name: _____ (Last, First, Middle)

Mailing Address: _____ (Street Address)

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

Social Security # _____ Date of Birth: _____ (Month) (Day) (Year)

Name of Employer/Group _____ 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: _____	❑	❑	❑	❑	

DeltaCare

Dentist Name: _____ Provider # _____ Location (State) _____

❑ 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 _____

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Employee Name: _____ SSN: _____

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Dependent	Add	Delete	Male	Female	Date of Birth
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
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