DELTA DENTAL
Delta Dental Insurance Company

PMI DENTAL HEALTH PLAN

Delta Dental (800) 521-2651
DeltaCare (800) 422-4234

ENROLLMENT/CHANGE FORM

TEXAS ONLY

FOR EMPLOYER USE ONLY	
Effective Date / /	Group No. (DDIC)
Full Time Hire Date / /	Group No. (DeltaCare)
Sublocation	

Make Your Coverage Selection

❑ Delta Dental ❑ DeltaCare ❑ POS Option

(DeltaCare, a dental HMO, is provided by Alpha Dental Programs and administered by PMI Dental Health Plan)

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

- ❑ 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, 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 ❑

DeltaCare Only (DHMO)

Network Facility Name: Network Facility #:

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					DeltaCare Only	
Dependent Name	Add/Delete	Male/Female (Check One)	Date of Birth (Month) (Day) (Year)		Network Facility Name	Network Facility #
Spouse:	❑ ❑	❑ ❑				
Dependent:	❑ ❑	❑ ❑				
Dependent:	❑ ❑	❑ ❑				
Dependent:	❑ ❑	❑ ❑				
Dependent:	❑ ❑	❑ ❑				
Dependent:	❑ ❑	❑ ❑				
Dependent:	❑ ❑	❑ ❑				

❑ **DeltaDental**-CANCEL ❑ **DeltaCare**-CANCEL ❑ **POS Option**-CANCEL

DeltaCare Only

What is your primary language? ❑ English ❑ Spanish ❑ Other _____

Do you have a disability affecting your ability to communicate or read which could be accommodated by providing you an Evidence of Coverage in a specific format?

❑ Yes ❑ No If so, what format?_____

- ❑ 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 may be guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____