ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

DELTA DENTAL®

PLEASE KEEP A COPY FOR YOUR FILES. *Please note that completing this form does not guarantee coverage.*

ALL GROUPS MUST COMPLETE THIS SECTION Note: Incomplete forms will be returned.

Delta Dental Group Number 10447 Sublocation Number —
Effective Date _____ Date of Hire _____ OR Date of Rehire _____
Name of Employer Roxana School District Location/Department —
Group Contact Kim Sheraka Phone 618-254-7543 Group Contact Email ksheraka@roxana schools.org

☐ Salaried ☐ Hourly
☐ Non-Union ☐ Union
☐ Other _____

EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

☐ **Yes,** I want to enroll in the dental and/or vision benefit plan(s) offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

☐ Delta Dental PPO/Delta Dental Premier

☐ **No,** I do not want to enroll in the dental benefit plan.
(If you are declining, please write your name below and sign at the bottom of this form.)

Social Security Number _____ Employee's Name _____ (First Name / MI / Last Name)
Alternate ID # _____ # Hours Worked _____ Job Title _____
Mailing Address _____ (Street / City / State / Zip)
Email Address _____ Phone Number _____
Marital Status: ☐ S ☐ M ☐ Other Date of Birth ____/____/____ ☐ Male ☐ Female

REASON FOR SUBMITTING THIS FORM

☐ Initial or Open Enrollment ☐ COBRA COBRA End Date ____/____/____ ☐ Retiree
☐ Reinstatement due to: ○ Rehire ○ Loss of Other Coverage ○ Other _____
☐ Add Dependent (list below) due to:
○ Birth ○ Adoption ○ Marriage ○ Loss of Other Coverage ○ Legal Guardianship ○ Disabled Dependent
○ Military Dependent ○ Other _____ Date of Qualifying Event ____/____/____
☐ Drop Dependent (list below) due to:
○ Age ○ Death ○ Divorce ○ Other Coverage Elsewhere Date of Qualifying Event ____/____/____
☐ Termination of Employment Date ____/____/____ ☐ Covered Under Spouse Date ____/____/____
☐ Name Change (Former Name _____) ☐ Address Change

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/dd/yyyy)	SEX (M or F)
☐	☐	1. Spouse:			
☐	☐	2. Child:			
☐	☐	3.			
☐	☐	4.			
☐	☐	5.			

DENTAL COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & One Child ☐ Employee & Children ☐ Entire Family
Is spouse covered under another dental plan? ☐ Yes ☐ No Other Carrier Name _____
Are dependents covered by spouse's plan? ☐ Yes ☐ No Spouse's Carrier _____
Spouse's Employer _____

I am requesting the coverage(s) I have selected above for which I am eligible under the contract issued by Delta Dental of Illinois for dental coverage and/or for vision coverage. I agree to continue membership in this program until the next open enrollment period. I certify that all the information stated on this form is complete and true to the best of my knowledge and Delta Dental of Illinois Insurance Company believing it to be true shall rely and act upon it accordingly. I authorize my employer/group to deduct from my pay and remit any required contributions for the cost of the selected coverage. This authorization is to remain in effect until Delta Dental of Illinois Insurance Company is notified in writing to the contrary.

Signature of Applicant _____ Date _____

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 369-0384 • Email eligibility@deltadentalil.com