DELTA DENTAL

DELTA DENTAL OF IDAHO
PO Box 2870; Boise, ID 83701
(208) 489-3582

Enrollment/Change Form

☐ **Enrollment Form**: *Complete* Sections I-III ☐ **Change Form**: *Complete* Sections I-IV

I. EMPLOYEE INFORMATION *(PLEASE PRINT)*

Name (First) (Middle Initial) (Last) | **Subscriber Number** or **SSN#** | **Date of Birth** (mo/day/year) | ☐ Male ☐ Female

Mailing Address (Street or Route) | **City, State, Zip**

Telephone #: | **Date Employed Full-time:** | **# Hours Worked/Week:** | Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

E-mail Address: | Do you want to obtain your EOB electronically? ☐ yes ☐ no | *Delta Dental of Idaho does not sell, share, rent, or lease personal information to third parties.*

Type of Coverage: ☐ Employee ☐ Employee + Spouse ☐ Employee + One (1) Child ☐ Employee + Two (2) or More Children ☐ Employee + Spouse + One (1) or More Children

Name of Employer: | **For Employer Use** | **Group Number:** | **Effective Date:**

II. DEPENDENT INFORMATION *(List all family members you wish to enroll)*

	Relationship to Applicant	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/year)		Subscriber Number or SSN#
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	

III. OTHER DENTAL COVERAGE *(Medical coverage information is not required)*

Do you or your dependents have **dental coverage** under another benefit plan? ☐ Yes ☐ No *If yes, please complete this section*

Name of Covered Person | Name of Covered Person's Place of Employment | Relationship to You | Date of Birth (mo/day/year)

Name of Dental Carrier | Dental Carrier's Address | Covered Person's Group #

Are you and all dependents listed above on the plan? ______ ______ ______

☐ Yes ☐ No If No, list covered dependents. ______ ______ ______

IV. CHANGE REQUESTS

Change current enrollment due to: ☐ Loss of previous coverage ☐ Marriage ☐ Divorce ☐ Birth ☐ Death ☐ Other ______ Date event occurred ______

Change my address to:

Change my name from: To:

I hereby apply for the group coverage for which I may be eligible, and I authorize the release of my records to Delta Dental of Idaho. I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.

Employee Signature: ______ Date: ______