



DENTAL ENROLLMENT/CHANGE FORM



Enrollment guidelines (except for Voluntary PPO):

1. Eligible employees electing coverage for themselves must enroll following completion of their eligibility period. Employees who do not enroll **cannot enroll at a later time** unless they show proof of loss of coverage under dental another dental program.
2. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage under another dental program.

Policy Information					
Company/Group Name The University Corporation 2501-2141			Delta plan (check one) <input type="checkbox"/> Premier <input type="checkbox"/> PPO <input checked="" type="checkbox"/> HMO		Employer # 5A05
Reasons For Addition/Change (check one)					
<input type="checkbox"/> New hire (eligible first of the month following wait period)		<input type="checkbox"/> Part-time to full-time (give date of full-time start date)		<input type="checkbox"/> Dependent change (provide reason & date of qualifying event)	
<input type="checkbox"/> Loss of coverage (provide proof — letter from prior carrier/employer)		<input type="checkbox"/> Fed-COBRA enrollment (provide termination date)		<input type="checkbox"/> Name or SS # correction (provide old and new number or SS #)	
<input type="checkbox"/> Domestic Partner		<input type="checkbox"/> Rehire (note rehire date) _____		<input type="checkbox"/> Reinstatement	
<input type="checkbox"/> Other (please explain) _____					
Comments:					Effective date:
Enrollee Information					
Enrollee name (Last name, first name)		Social security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	Date of hire
Mailing address		City	State	ZIP	Phone
Dependents to be Enrolled or Deleted					
Spouse/domestic partner name (last, first)		Action <input type="checkbox"/> Add <input type="checkbox"/> Term	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	
Child name (Last, First)		Action <input type="checkbox"/> Add <input type="checkbox"/> Term	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	If 19 years or older check one: <input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled
		<input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled
		<input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled
		<input type="checkbox"/> Add <input type="checkbox"/> Term	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Full-time student under 25* <input type="checkbox"/> Disabled <i>*Provide proof of full-time student status</i>
HMO (DeltaCare) Enrollees Must Fill Out This Section					
Provider choice: Dental office ID #		Dental office city		Dental office name	
Signature					
Enrollee signature				Date	

This form must be received no later than the 25th of the month prior to the desired effective date. Please allow 5 days to process.