Patient Direct Enrollment Form

Please select which enrollment type you would like to choose: Individual

- You must live in the state of Oklahoma to enroll
- You must be over 18 years old to join

Family

This is not insurance

Employer: _____

GROUP#/SUBGROUP# | | | | | | | | | | | |

LOCATION CODE | | | | | | |

Enrollee Information: *(please complete in ink for enrollment/eligibility updates)*

LAST NAME		FIRST NAME		MARITAL STATUS M S
SUBSCRIBER SOCIAL SECURITY NUMBER	BIRTH DATE	FULL-TIME HIRE DATE	EFFECTIVE DATE	
ADDRESS				
CITY	STATE	ZIP	CHECK IF THIS IS A NEW ADDRESS	

EMAIL: _____

Type of Enrollment Update EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION:

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:

NEW ENROLLMENT REINSTATEMENT

QUALIFYING EVENT OPEN ENROLLMENT

TERMINATION AS OF _____

CHANGE IN CURRENT ENROLLMENT STATUS FOR SUBSCRIBER DEPENDENTS

REASON FOR CHANGE:

DIVORCE MARRIAGE NAME CHANGE

ADOPTION/LEGAL GUARDIANSHIP OTHER _____

Be Advised: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete or missing information is guilty of a felony.

By checking this box as the enrollee, you confirm explicit consent regarding Delta Dental of Oklahoma's collection, use, disclosure, maintenance, storage, and disposal of Customer Protected Health Information and Personally Identifiable Information as described in the enrollment form's Privacy Policy online at DeltaDentalOK.org/PrivacyPolicyPDN, or by mail upon request, and Delta Dental of Oklahoma's Notice of Privacy Practices available at DeltaDentalOK.org/HIPAANoticePDN, or by mail upon request.

By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma, and acknowledge I have read the privacy policy detailed via the links above.

Enrollee Signature: _____ Date: _____

Please read the following information carefully before completing this form. You should fill out this form if you are enrolling in this program or updating/changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Enrollee Information – This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the primary enrollee. Please print clearly in ink.

Full-time Hire Date: Date you were hired with your employer.

Effective Date: Date Delta Dental enrollment takes effect for you (and/or your dependents, if enrolled).

Enrollment/Eligibility Update Information – This section should only be completed if at least one (1) of the following is true:

- You are enrolling your or a family member for the first time
- Your enrollment was terminated and is not being reinstated
- You are making changes to your current enrollment information

New Enrollment: Check for first time enrollment for yourself or your eligible dependents.

Reinstatement: Check for reinstatement enrollment for yourself or your eligible dependents.

Termination of Benefits: Check only if you are terminating Delta Dental enrollment for yourself or a family member.