Enrollment/Eligibility Update

DELTA DENTAL

PLAN TYPE:
(AS ESTABLISHED BETWEEN EMPLOYER AND DELTA DENTAL)

- ☐ DELTA DENTAL PPO
- ☐ DELTA DENTAL PPO – PREVENTIVE PLUS
- ☐ DELTA DENTAL PPO – PLUS PREMIER
- ☐ DELTA DENTAL PPO – PLUS PREMIER "ELITE"
- ☐ DELTA DENTAL PPO – CHOICE
- ☐ DELTA DENTAL PPO – CHOICE ADVANTAGE
- ☐ DELTA DENTAL PPO – POINT OF SERVICE

Employer: _____ GROUP# _____ SUBGROUP# _____ LOCATION CODE _____

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

SUBSCRIBER NAME (LAST)		(FIRST)		
SUBSCRIBER SOCIAL SECURITY NUMBER	BIRTH DATE	FULL-TIME HIRE DATE	COVERAGE EFFECTIVE DATE	STATUS ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving Dep. ☐ Other: _____
ADDRESS				
CITY	STATE	ZIP	☐ CHECK IF THIS IS A NEW ADDRESS	

EMAIL: _____

Enrollment/Eligibility Update Information – EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION:

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:
☐ NEW ENROLLMENT ☐ REINSTATEMENT ☐ OPEN ENROLLMENT
☐ COBRA ELECTION ☐ TERMINATION OF BENEFITS
☐ TERMINATION OF EMPLOYMENT AS OF _____

☐ CHANGE IN CURRENT ENROLLMENT STATUS FOR ☐ SUBSCRIBER ☐ DEPENDENTS
REASON FOR CHANGE:
☐ DIVORCE ☐ MARRIAGE ☐ NAME CHANGE ☐ LEGAL GUARDIANSHIP
☐ ADOPTION ☐ OTHER _____

GROUP TRANSFER FROM GROUP# _____ SUBGROUP# _____ TO GROUP# _____ SUBGROUP# _____

Dependent Enrollment/Eligibility Update Information: (please complete for spouse and/or dependent children for enrollment/eligibility update)

SPOUSE NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE

WARNING: 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 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 below.

☐ 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/PrivacyPolicyGroup, or by mail upon request, and Delta Dental of Oklahoma's Notice of Privacy Practices available at DeltaDentalOK.org/HIPAANotice, or by mail upon request.

Subscriber Signature: _____ Date: _____