DELTA DENTAL®

Eligibility Enrollment/Update

NO FORM IS REQUIRED IF WAIVING BENEFITS

Check: ☐ **Indiana** ☐ **Michigan** ☒ **Ohio**

Dental Client#/Subclient#: 11659 - 0001

Client Name: Waynedale Local School District

Vision Client#/Subclient#: _____ - _____

Plan Enrollment/Update Information (*Please indicate type of update and fill in appropriate information*):

Type of Update: ☐ New Enrollment ☐ Termination of Benefits ☐ Change/Correction to Information ☐ Reinstatement

Client/Subclient Transfer
From: Client#/Subclient# **To:** Client#/Subclient#

_____ - _____ _____ - _____

Coverage Effective Date: (##/##/####)

_____ / _____ / _____

Change is for: ☐ Subscriber ☐ Spouse ☐ Dependent

Subscriber Information (*Please fill in for first-time enrollments, changes or corrections*):

Subscriber Name (Last) (First) (M.I.)

_____ _____ _____

Sex: ☐ Male ☐ Female

Status*: ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving ☐ Special Health Care Needs

Social Security Number Birthdate (##/##/####) Hire Date (##/##/####)

_____ - _____ - _____ _____ / _____ / _____ _____ / _____ / _____

☐ Dental ☐ Vision

Street Address

_____

☐ Check here if this is a new address

City State Zip Code

_____ _____ _____

Spouse/Dependent Information (*Please fill in for first-time enrollments, changes or corrections*):

SPOUSE Name (Last) (First) (M.I.)

_____ _____ _____

☐ Dental ☐ Vision

Sex: ☐ Male ☐ Female

Social Security Number Birth Date

_____ - _____ - _____ _____ / _____ / _____

Status*: ☐ Legal ☐ Surviving ☐ Special Health Care Needs

DEPENDENT #1 Name (Last) (First) (M.I.)

_____ _____ _____

☐ Dental ☐ Vision

Sex: ☐ Male ☐ Female

Social Security Number Birth Date

_____ - _____ - _____ _____ / _____ / _____

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Special Health Care Needs

DEPENDENT #2 Name (Last) (First) (M.I.)

_____ _____ _____

☐ Dental ☐ Vision

Sex: ☐ Male ☐ Female

Social Security Number Birth Date

_____ - _____ - _____ _____ / _____ / _____

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Special Health Care Needs

DEPENDENT #3 Name (Last) (First) (M.I.)

_____ _____ _____

☐ Dental ☐ Vision

Sex: ☐ Male ☐ Female

Social Security Number Birth Date

_____ - _____ - _____ _____ / _____ / _____

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Special Health Care Needs

DEPENDENT #4 Name (Last) (First) (M.I.)

_____ _____ _____

☐ Dental ☐ Vision

Sex: ☐ Male ☐ Female

Social Security Number Birth Date

_____ - _____ - _____ _____ / _____ / _____

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Special Health Care Needs

*See reverse side for instructions.

[NOTE: Vision is only available if the group contract includes it]

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

Subscriber's Signature: _____ **Date:** _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or 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.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

Enrollment:	Check for first time enrollment for yourself, spouse or your dependents.
Reinstatement:	Check for reinstatement coverage for yourself, spouse or your dependents.
Change/Corrections:	When reporting a change or correction, the information that is incorrect or has changed should be listed. Please include both the first and last names of any individuals for whom you are enrolling or submitting a change or correction.
Termination of Benefits:	Check only if you are terminating Delta Dental coverage for Subscriber, Spouse or Dependent.
Client Transfers:	Use the "FROM: Client#/Subclient# and TO: Client#/Subclient#" when transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

Subscriber Information – This section must be completed for us to process your enrollment, changes or corrections to your record. All information should apply to you, the primary subscriber. Please print clearly or type including first and last name.

Coverage Effective Date: The date that Delta Dental coverage or changes takes effect.

Status Definitions (Please select only one status):

Active:	You are a current/active subscriber.
Retiree:	You are retired and your group continues to provide you with dental benefits.
COBRA:	You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**
Surviving:	The surviving spouse or child of a deceased subscriber.

Spouse/Dependent Information – This section must be completed for us to process your enrollment, changes or corrections to the record(s) for a spouse or dependent. Please print clearly or type including first and last name.

Dependent Status Definitions:

Legal:	Your current spouse.
Surviving:	The surviving spouse or child of a deceased subscriber.
IRS Dependent:	An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried or married dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.
Disabled:	Your permanently disabled child.
Sponsored:	**(Use only if specified in your Client's contract with Delta Dental)**. Sponsored Dependents whom you are legally responsible for could include parents, grandparents and foreign exchange students.
Special Health Care Needs:	**(Use only if specified in your Client's contract with Delta Dental).** Includes any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.



Email: eligibility@deltadentalmi.com



Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916

NO FORM IS REQUIRED IF WAIVING DENTAL OR VISION BENEFITS