



Delta Dental Plan of Idaho

555 E. Parkcenter Boulevard ▪ Boise, Idaho 83706 ▪ (208) 489-3582

Enrollment Form Complete Sections I-III

Change Form Complete Sections I-V

**I. EMPLOYEE INFORMATION (Please Print)**

Name (First) (Middle) (Last)			Social Security Number				Date of Birth (mo/day/yr)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Street or Route)			City, State, Zip						
E-mail		Telephone Number		Date Employed Full-time (mo/day/yr)		No. of Hours Worked Per Week		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Type of Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + One (1) Child <input type="checkbox"/> Employee + Two (2) or More Children <input type="checkbox"/> Employee + Spouse + One (1) Child <input type="checkbox"/> Employee + Spouse + Two (2) or More Children									
Name of Employer				<b>For Employer Use</b>		Group Number		Effective Date	

**II. DEPENDENT INFORMATION (List all family members you wish to enroll. If enrolling one eligible child, all must be enrolled.)**

<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant Spouse Child Stepchild Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant Spouse Child Stepchild Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant Spouse Child Stepchild Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant Spouse Child Stepchild Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant Spouse Child Stepchild Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number / /

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

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

Name of Covered Person		Name of Covered Person's Place of Employment		Relationship to You	Date of Birth (mo/day/yr)
Name of Dental Insurance Carrier		Dental Insurance Carrier's Address		Covered Person's Group No.	Covered Person's Social Security No.
Are you and all dependents listed above on the plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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 \_\_\_\_\_ (mo/day/yr)

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 Plan of Idaho. I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.

Employee's Signature: _____	Date: _____
-----------------------------	-------------