

Applicant: Select an insurance plan or Patient Direct discount plan (below).
 Delta Dental Premier*
 Delta Dental PPOSM
 Delta Dental PPOSM Plus Premier
 Exclusive Panel Option (EPO)
 Delta Dental MAC PPOSM

Delta Dental Patient Direct* (for Patient Direct, the following fields are mandatory):

 1. Patient Direct Provider Name: _____ 2. Patient Direct Provider Number: _____

New Enrollment
 Waive Coverage
 Change Coverage
 Active
 Retired
 COBRA/State Continuation

Employee Information (please print clearly or type)

| | | | | |
|-------------------------------|-----------------------|----------------------|------------------------|-------------|
| Employer: | | Group #: | Subgroup #: | |
| SSN: | Date of Birth: | Date of Hire: | Effective Date: | |
| Last Name: | | First Name: | M / F | |
| Street Address: | | City: | State: | Zip: |
| Contact Email Address: | | | Cell Phone: | |

Would you like to receive communications from Delta Dental of Colorado by email and text message?
 Yes No

 Your email address and cell phone will not be used for any purpose other than communications from Delta Dental of Colorado.

Select Coverage:
 Employee Only
 Employee and Spouse
 Employee and Children
 Employee, Spouse, and Children

Please list all dependents. All fields are required.

| Add | Delete | Last Name | First Name | SSN | Date of Birth | M | F |
|--------------------------|--------------------------|-----------|------------|-----|---------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |

If you need more space to list additional dependents, please use a second enrollment form.

Changes to Existing Eligibility

Date change is effective (mm/dd/yyyy): _____

| Reason for change/explanation: | List effective date for checked boxes below. | |
|--|--|-------------|
| <input type="checkbox"/> Name Change (list above) | <input type="checkbox"/> Marriage | Date: _____ |
| <input type="checkbox"/> Cancel Coverage | <input type="checkbox"/> Birth/Adoption* | Date: _____ |
| <input type="checkbox"/> Employment Terminated | <input type="checkbox"/> Divorce | Date: _____ |
| <input type="checkbox"/> Reinstatement of Coverage (see reverse) | <input type="checkbox"/> Death | Date: _____ |
| <input type="checkbox"/> Address Change (list above) | <input type="checkbox"/> No Longer Eligible | Date: _____ |
| <input type="checkbox"/> COBRA/State Continuation (list start date above) | <input type="checkbox"/> Part-time to Full-time | Date: _____ |
| <input type="checkbox"/> Late Enrollment (if applicable) | <input type="checkbox"/> Retiree | Date: _____ |
| <input type="checkbox"/> Family Status Change | <input type="checkbox"/> Add Disabled Child* | Date: _____ |
| <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent | <input type="checkbox"/> Transfer to Group/Subgroup: | Date: _____ |
| <input type="checkbox"/> Other Reason for Change: _____ | | |

I understand that the terms of the contract between Delta Dental and my company may not allow for late enrollment for my dependents. The contract may allow for late enrollments but may require waiting periods or additional limitations.

Employee's Signature

Date

It is unlawful to knowingly provide false, incomplete, or misleading information to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

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

Status Definitions

Status definitions appear near the top of the enrollment form. Please check the appropriate box in each section.

New Enrollment: Check for first-time enrollment for you or your dependents.

Waive Coverage: Check if you do not want to take dental coverage. Please note that not all plans allow waiving of coverage.

Change Coverage: If you are making changes to your existing enrollment information, please check this box and complete the appropriate information under Changes to Existing Eligibility near the bottom of the form.

Also complete the following:

Active: You are a current employee.

Retired: You are retired, and your group continues to provide you with dental benefits.

COBRA: You are no longer an active employee, but you have continued self-paid coverage under COBRA.

Group Number/Subgroup Number

Please enter the Delta Dental group number for the program you are enrolling in. If your employer uses subgroup numbers, please include the appropriate subgroup number. If you are unsure of your group and/or subgroup number, please contact your human resources department.

Employee Information

This section must be completed to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date

The date that Delta Dental coverage takes effect for you and/or your dependents.

List of Dependents

This section should be completed when:

- 1.) Enrolling dependents and/or
- 2.) You have checked Change Coverage and are changing information that was previously submitted to Delta Dental. Please include both first and last names, date of birth, and Social Security numbers for any individuals for whom you are enrolling or submitting a change or correction.

Standard Dependent Definitions (May Vary)

Spouse: Your legal spouse.

Child(ren): Includes unmarried and married child(ren), step-child(ren), legally adopted child(ren), and court-ordered foster child(ren) in a parent/child relationship who meet the age limits specified between your employer and Delta Dental.

Common Law: If you add a common-law spouse and later cancel coverage for this individual, you will be required to provide legal documentation before another common-law can be added to the plan. List Common Law as spouse.

Civil Union: Civil Union is included in all fully insured employer group contracts with Delta Dental. Fully insured groups offer this as a dependent option; therefore, please list partner as a spouse and provide all information requested.

Domestic Partner: May not be included in all employer group contracts with Delta Dental. If your group offers this as a dependent option, please list partner as a spouse and provide all information requested.

Disabled or Full-time Student: If you have a disabled child or a full-time college student, please provide supporting documentation.

Changes to Existing Eligibility Information

This section should be completed only if you are making changes to your existing enrollment information.

Reinstatement: Check for reinstatement coverage for yourself or your dependents. Please provide reason for reinstatement (divorce, loss of coverage, etc.) under Other Reason for Change.

Cancel Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member. This is not the same as Employment Termination.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, please include an effective date of change and clearly state the reason for the change.

**Please attach supporting documentation to the enrollment form and submit to your HR office.*

Privacy Policy Statement

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof who knowingly provides false, incomplete, or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits to the Colorado Division of Insurance.

Enrollment forms, changes, and those items requiring supporting documentation should be submitted to your human resources department office so they can make changes to your plan through Delta Dental of Colorado's employer portal.

Delta Dental of Colorado
PO Box 5468
Denver, CO 80217-5468

Phone: 303-741-9300, ext. 3900