



Applicant: Select an insurance plan or Patient Direct discount plan (below).

Delta Dental Premier® Delta Dental PPOSM

Exclusive Panel Option (EPO)

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 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: _____

Email Address: _____

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

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

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"/>
<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.

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.