Delta Dental of Arizona
P.O. Box 43000, Phoenix, AZ 85080-3000
Phone (602) 938-3131 — (800)-352-6132

Enrollment Change of Status Form

Please Print Using Blank Ink – *Press Firmly – Multiple Copies*

FOR DELTA USE ONLY

Group #: ________________________________

Eff. Date: ________ Wait Start Date: __________

Rate Code: ________

SECTION A: QUALIFYING EVENT (Member Please ✓ One)

❑ New Hire/Open Enrollment. (Complete All Sections) ❑ Termination (Date) _________________________

❑ Add/Delete/Dependents(s): Indicate Date of Qualifying Event (Complete Section B, C)

Marriage: ___________________________ Birth: _______________________________

Divorce: ___________________________ Adoption: _______________________________

Other: ___________________________

❑ COBRA Continuation ❑ Address Change

❑ COBRA Qualifying Event ❑ Name Change

❑ Termination To: _______________________________

❑ Divorce From: _______________________________

❑ Death of Employee

❑ Loss of Dependent Status ❑ Decline Coverage (Complete Sections B, E)

SECTION B: MEMBERSHIP INFORMATION

Social Security Number / EIN

Marital Status ❑ Single ❑ Married **Gender** ❑ M ❑ F

Date of Birth _______/_______/_______

Date of Hire _______/_______/_______

Member's Last Name	First	Middle Initial	Home Telephone

Home Address (Mailing)	City	State	Zip Code

Employer/Group Name	Position Title	Hours Per Week

SECTION C: DEPENDENT INFORMATION

Add	Chg	Del	Last Name (if different) First, M.I.	Social Security Number	Relationship to Member*	Gender (M/F)	Date of Birth	Full-Time Student	
								Yes	No
					SPOUSE				

*If dependent is over the age of 19 and is a full-time student, the following information is required; name of institution, number of credit hours and year attending. If the dependent is disabled, current medical documentation is required.

SECTION D: DUAL COVERAGE

Do you or any member of your family have coverage under another group dental insurance plan? If so, please list.

❑ YES – Please complete the following information (right and below). ❑ Medical ❑ Dental ❑ COBRA ❑ Retiree

❑ NO – Please skip to Section E

Insurance Company Name	Insurance Company Phone Number	
Name of Policyholder	Policy Holder's Social Security Number	
Employer Name	Policyholder's Date of Birth _______/_______/_______	Effective Date of Coverage _______/_______/_______

Name of Dependent	**Relationship to Policyholder**

SECTION E: AUTHORIZATION

I hereby apply for membership with Delta Dental Plan of Arizona, Inc. pursuant to the terms specified on the reverse side of this form, which are hereby incorporated by reference.

Member's Signature / Authorization	**Social Security Number**	**Date Signed**

WHITE: Delta's Copy YELLOW: Group Policyholder's Copy PINK: Member's Copy

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I hereby apply for membership with Delta Dental of Arizona, Inc. (Delta Dental) and I understand and agree that my coverage, and that of any dependents, will become effective on the date established by my dental contract (referred to as "Plan"). I agree to be bound by the provisions of the Plan. Any dependents that are later added to my Plan will have different effective dates.

My employer or group administrator is authorized to deduct my share of dental premiums, if any is required of me, from my wages for 12 months and 12 month renewal periods, and is authorized to remit a premium to Delta Dental and to receive all notices from Delta Dental relating to my coverage. I understand that enrollments are for consecutive 12-month period(s) and my contribution is subject to change on the annual anniversary date. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period.

I am responsible to notify Delta Dental upon any change that would make me or any dependent ineligible for coverage.

I will cooperate with Delta Dental and furnish all information requested to enforce its right to coordinate benefits.

I hereby authorize any physician, dentist, hospital, or insurer having records of information concerning health history or other insurance for me and those persons specified as dependents to furnish such records, data, or information as may be requested by Delta Dental or their duly authorized representative to review eligibility, determine benefits (if any), group contract administration, detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. I hereby authorize Delta Dental to release information related to my benefits and those persons specified as dependents benefits under this plan to any dental office. I understand that this authorization is valid for a minimum of 12 consecutive months from the date signed and/or the latest renewal during the open enrollment period. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I, or any authorized representative may receive, upon request, a copy of this authorization. This information may also be given by Delta Dental to its legal representatives.

To the extent allowed by law, Delta Dental is authorized to furnish all information and copies of records requested by other insurers, dental plans or other parties for the purposes of determining eligibility for coverage or benefits, coordinating benefits, utilization review or audit. I give Delta Dental, its legal representatives or any person or organization administering claims on its behalf, permission to release to my employer or group policyholder a summary of claims incurred by me or my eligible dependents for the purpose of verifying the claims submitted under my plan, utilization review, or for the purpose of conducting an audit of operations or services. If my benefits are provided under a self-funded plan, the above listed parties are authorized to release any necessary information to the self-funded plan, and I understand that all information so released is the property of my employer and may be retained by my employer.

Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this application, the identification card and the group contract will constitute the contract.

Uses and Disclosures of Health Information: At Delta Dental, we use health information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. We NEVER sell any information we collect while processing transactions on your request. You can be assured that when processing or servicing a transaction at your request, only the minimum necessary information regarding your account or personal history information will be used or disclosed, as permitted by law. Delta does not routinely record the identity of the recipient of the information that we have disclosed to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. For more information about our privacy practices, please visit www.deltadentalaz.com under privacy policy or contact Customer Service, Phone: (602) 938-3131 or (800) 352-6132, Email: customerservice@deltadentalaz.com.