



ENROLLMENT FORM

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517
800-84-DELTA

Please print

Employer Group Name		Delta Dental Group Number	Date of Hire	Location No. (if applicable)
Social Security No. / Subscriber I.D. No.		Subscriber Name: First - Last		
Date of Birth - MM/DD/YYYY		Street Address / P.O. Box No.		
Effective Date of Action:	Apt. No.	City	State	Zip

QUALIFYING EVENT

Open Enrollment
 New Hire/Re-hire
 Marriage
 Divorce
 Birth or Adoption
 Workers' Compensation
 Return From Leave of Absence
 Dependent's Loss of Coverage
 Full-Time/Part-Time Status
 Death of a Member

DEPENDENT INFORMATION			
First Name Only <small>If last name differs, please indicate in "other remarks" below.</small>	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			<input type="checkbox"/>

ACTION CODE (Check One) *(Changes must be made on the first of the month)*
 Explain in "Other Remarks" if necessary.

ADDITIONS:

New Subscriber
 Add Dependent to Existing Family Coverage
 Reinstatement

TERMINATION:

Remove Subscriber
 Remove Dependent/Student (List dependent name.)

STATUS CHANGE:

Individual to Family
 Family to Individual
 Name / Address Change
 Transfer from Sublocation # _____ to # _____

COBRA:

Reinstatement of Subscriber
 Add Dependent: - (From Prior Subscriber ID # _____)

Corrections / Other Remarks (Please Explain)

Type of Coverage (Check One) Individual Family

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? No Yes *If Yes, Please Complete the Section Below.*

Other Dental Insurance Name: _____ Type of Coverage: Individual Family

Other Dental Insurance Address: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.
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MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? No Yes *If Yes, Please Complete the Section Below.*

Name of Medical Insurance Company/HMO: _____ Type of Coverage: Individual Family

Name of Health Plan/Type of Coverage: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.
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I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ Date _____ Benefits Administrator Authorization _____ Date _____