△ DELTA DENTAL

Signature:

ENROLLMENT/CHANGE FORM

DV-ENR-11-B

T. 0	Delta Dental of Arkansas P.O. Box 15965 North Little Rock, AR 72231 E-mail: eligibility@ddpar.com Fax (501) 992-1890					☐ New Enrollment ☐ Status Change ☐ Dental Only ☐ Vision Only					□ Address Change □ Termination □ Dental/Vision □ Cobra □ Social Security Number			
Effective Date				oup Nu	ımber:									
Month	Day	Yea	r Gro	oup Na	ıme:						Subscriber's Id	entifier (i	f applicable)	
LAST N	AME:						FIRST:						MI:	
STREET	ADDR	ESS:												
										_ STAT	E:	ZIP:		
EMAIL:									_	NOTE:	Certain medical condition dependents to additional	s may ent benefits. I	title you and/or your Please mark any	
Date of Birth Marital Status						conditions that apply to you						er section	2 below, please enter	
				Sing!	le	□ Male					Enter P for pregnant, D for diabetes, and H for Heart Disease) ☐ Pregnancy - Expected due date			
MM	DD /	YY		□ Marr	ried	□ Fema	ale MM	DD /	YY	☐ Diab	etes - Date of onset t Disease - Date of onset			
1. CO\			ANGE	Ç.							next to the reason			
Type cov					e)		ı			• • •	☐ Change Coverage	` ′	your change	
Dental Vision					,		☐ Add Dependent(s) listed below ☐ Remove Dependent(s) listed below ☐ Name Change ☐ Late Entrance (employee)				☐ Address Change only ☐ Qualifying event			
				Employ	/ee						☐ Late Entrance (dependent)			
☐ Employee/Spouse ☐ Employee/Spo										Date of event ☐ Loss of spouse's		ge		
☐ Employee/Child ☐ Employee/Child					□ Divorce □ No longer						ependent child			
☐ Employee/Children ☐ Emp					□ Full Time Student □ No					☐ Death of depend☐ No longer Full ☐	No longer Full Time Student			
					☐ Other									
☐ Employee/Family ☐ Employee/Family						COBRA effective date								
						,	R AFFECT					<u> </u>		
Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if	different)	Firs	st	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)	
3. AUT				1	1 (1 1	141	C : 1 1		1: 1	2 14 D	1 64 1		1 (: 1 1:	
without lin tion is mad collecting i	nitation, its le for each information collecting on form.	s claims individ n in con informs	and custoual to be inection varion in c	omer ser enrolled vith enro	vice perso or affecto llment, co	onnel) all inf ed by this cha overage reins	formation necess ange. The authorstatement, or rec	sary to dete orization is quests to cl	ermine (1) el valid for 30 nange benefi	ligibility for months for the au	al of Arkansas, its agent for coverage and (2) cover from the date this form is athorization is valid for the representative is entitle	ered bene signed f he term o	efits. This authorization the purpose of coverage for the	
I certify that	at the infor	mation	supplied	by me or	n this for ents false	m is accurate information	e to the best of n in an application	ny knowled on for insu	dge. Any per	rson who l ty of a crii	knowingly presents a fal me and may be subject to	se or frau o fines an	idulent claim for ad confinement in	
☐ I have l☐ I autho				nity to e	enroll in	the dental a	and/or vision p	orogram th	rough Delt	ta Dental	; however, I waive co	verage a	at this time.	

Date: