DELTA DENTAL

ENROLLMENT/CHANGE FORM

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 ☐ Address Change ☐ Termination

☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date

Month	Day	Year
01	01	2025

Group Number: 2699

Group Name: Cross Church

Social Security Number

Subscriber's Identifier (if applicable)

LAST NAME: _____ FIRST: _____ MI: ____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

Date of Birth / / MM DD YY

Marital Status ☐ Single ☐ Married

Sex ☐ Male ☐ Female

Date of Hire / / MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code."

Enter P for pregnant, D for diabetes, and H for Heart Disease)

☐ Pregnancy - Expected due date _____

☐ Diabetes - Date of onset _____

☐ Heart Disease - Date of onset _____

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

Dental
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

Vision
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change
☐ Late Entrance (employee)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other _____

☐ COBRA effective date _____

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Date of event _____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student

_____

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	**Vision**	Add	Remove	EBD Code	Onset Date	**Last (if different)**	**First**	**MI**	**Relationship**	**Sex** M/F	**Birthdate** (MM/DD/YY)
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time**.
☐ I authorize payroll deductions.

Signature: _____ Date: _____