DELTA DENTAL

Enrollment/Change Request

Employer Group Information – To be completed by Employer

Group Name	Group Number	Sublocation/Store location
Clayton Board of Education	07755	00001 /

(A) Type of Activity – To Be Completed by Employer. Refer to instructions on back before completing this form. Print clearly.

1. Enrollment (☑) **New Enrollee / Subscriber** **Effective Date** **Date of Hire**

2. Change – Check all that apply

	Date of Event	Reason
☐ Add Spouse		
☐ Add Domestic Partner		
☐ Add Dependent Child		
☐ Name Change		
☐ Change Plan		
☐ Other		
☐ Add/Change Office ID Numbers		

3. Remove or Terminate – Check all that apply

	Effective Date	Reason
☐ Remove Spouse*		
☐ Remove Domestic Partner*		
☐ Remove Dependent Child*		
☐ Employee Withdrawal/Termination		

NOTE: Employee must be enrolled for spouse/dependents(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Employer for available options.

Coverage for: ☐ **Employee** ☐ **Dependents**

Length of Continuation: ☐ 12 months ☐ 18 months ☐ 29 months ☐ 36 months ☐ Total Disability* Attach proof of total disability

Date of Loss of Coverage: __/__/__ Date of Qualifying Event: __/__/__

Billing: ☐ Home ☐ Group

(B) Employee Information – Complete Sections (B-G)

Last name, First name, MI _____ Social Security Number _____ Home Telephone _____

E-mail Address _____ Home Address _____ Apt # ____ City, State _____ Zip Code _____

Employer Name _____ Work Telephone _____ Work Address _____

City, State _____ Zip Code _____ Date of Employment __/__/__ Hours Worked per week _____

(C) Plan Option – Your selection must be offered by your Employer Check one: ☐ Delta Dental Premier® ☐ Delta Dental PPO℠ ☐ Advantage Program ☐ Delta Dental PPO plus Premier ☐ DeltaCare®

(D) Individuals Covered – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. (Attach proof if full-time post-secondary student. Attach proof of disability.) Non-tenured employees must select Employee only coverage.

	(A) Add (C) Change (R) Remove		Last Name First Name, MI	Sex M F	Birthdate MM/DD/YYYY	Social Security Number	Other Health Coverage	Previous Coverage Check if Yes
Employee	_ R	__	_____	____		_____	_____	__☐__
Domestic Partner (If Coverage offered)	_ R	__	_____	____		_____	_____	__☐__
Spouse	_ R	__	_____	____		_____	_____	__☐__
Child	_ R	__	_____	____		_____	_____	__☐__
Child	_ R	__	_____	____		_____	_____	__☐__
Child	_ R	__	_____	____		_____	_____	__☐__
Child	_ R	__	_____	____		_____	_____	__☐__

(E) Other/Previous Insurance

Is your spouse employed? ☐ Yes ☐ No If "Yes", give name and address of your spouse's employer.

_____

If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#.

_____

If "Yes" to Previous Coverage, identify names(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

_____

(F) Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes", who and at what address?

_____

Explain the circumstances

_____

If any dependent's last name differs from yours, explain the circumstances.

_____

(G) Employee Signature *If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required _____ Date ☐ E-mail Address _____

(H) Employer Verification – To be Completed by Employer

Employer Signature – Required _____ Title _____ Date ☐

Instuctions

Employer

*Complete the Employer Group Information in the upper left corner of the form.
*Section A - Type of Activity:Check boxes indicating reason(s) for submitting application.
*Complete Section (H) – Employer Verification (in the upper left corner of the second page)of the form.
*Employer must complete this section for all new enrollments, coverage changes and terminations.
*Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee – Complete Sections (B-G)

Section (B) – Employee Information

- Complete all information in order for your application to be processed.

Section (C) Plan Option:

Check one Plan option box ( ) Delta Dental Premier ( ) Delta Dental PPO
( ) Delta Dental POS ( ) Delta Dental PPO Advantage Program ( ) DeltaCare
Select only an option offred by your employer.

Section (D) – Individuals Covered:

- Add/Change/Remove – Use "A","C",or"R" to indicate wqhether you are adding,changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex,Birthdate,and Social Security number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school **or its authorized representative** confirming full-time student status. If dependent is disabled and being contiuned beyond the limiting age, attach proof of disibility.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section (F) – Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID number for the dentist (if applicable). Indicate office ID number selection(s) on the form.

Section (E) – Pre-Existing Conditions Statement

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in the group coverage in a group of 2-5 employees and by late entrants.

Section (F) – Other/Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section (G) – Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section (H) – Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section (I) – Employer Verification

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditons of Enrollment

Application Acknowledgment and Agreements

1. On behalf of myself and the dependents listed on the reverse side I agree to or with the following:
   a)I authorize the sources stated below to give Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf, information about me and my minor childern, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or medical condition. Authorization sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier, any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not afect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefits plan is subject to criminal and civil penalties.