



Enrollment/Change Form

DELTA DENTAL OF IDAHO
 555 E. Parkcenter Blvd
 Boise, ID 83706
 (208) 489-3582

Enrollment Form: Complete Sections I-III Change Form: Complete Sections I-IV

I. EMPLOYEE INFORMATION (Please print)

Name (First)	(Middle Initial)	(Last)	Subscriber Number or SSN#	Date of Birth	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (PO Box or RR)			City, State, Zip		
Telephone #:	Date Employed Full-time:	# Hours Worked/Week:	Marital Status:		
			<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
E-mail Address:			By providing my email address, I agree to receive communications regarding my Policy electronically. This authorization may be revoked by calling Customer Service at (800) 356-7586.		
Name of Employer:			For Employer Use	Group Number:	Effective Date:

II. DEPENDENT INFORMATION (List all family members you wish to enroll)

Relationship to Applicant		SSN#	Dependent's Name (First, MI, Last)	Gender	Date of Birth (mo/day/year)
<input type="checkbox"/> Add	<input type="checkbox"/> Spouse <input type="checkbox"/> Child			<input type="checkbox"/> Male	
<input type="checkbox"/> Remove	<input type="checkbox"/> Stepchild <input type="checkbox"/> Other			<input type="checkbox"/> Female	
<input type="checkbox"/> Add	<input type="checkbox"/> Spouse <input type="checkbox"/> Child			<input type="checkbox"/> Male	
<input type="checkbox"/> Remove	<input type="checkbox"/> Stepchild <input type="checkbox"/> Other			<input type="checkbox"/> Female	
<input type="checkbox"/> Add	<input type="checkbox"/> Spouse <input type="checkbox"/> Child			<input type="checkbox"/> Male	
<input type="checkbox"/> Remove	<input type="checkbox"/> Stepchild <input type="checkbox"/> Other			<input type="checkbox"/> Female	
<input type="checkbox"/> Add	<input type="checkbox"/> Spouse <input type="checkbox"/> Child			<input type="checkbox"/> Male	
<input type="checkbox"/> Remove	<input type="checkbox"/> Stepchild <input type="checkbox"/> Other			<input type="checkbox"/> Female	

III. OTHER DENTAL COVERAGE (Medical coverage information is not required)

Do you or your dependents have dental coverage under another benefit plan? Yes No If yes, please complete this section

Name of Covered Person	Name of Covered Person's Place of Employment	Relationship to You	Date of Birth (mo/day/year)
Name of Dental Carrier	Dental Carrier's Address	Covered Person's Group #	

Are you and all dependents listed above on the plan? _____

Yes No If No, please list covered dependents. _____

IV. CHANGE REQUESTS

Change current enrollment due to: Loss of previous coverage Marriage Divorce Birth Death Other _____ Date event occurred _____

Change my address to:	Change my email to:
Change my name from:	To:

I hereby apply for the group coverage for which I may be eligible, and I authorize the release of my records to Delta Dental of Idaho. I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.

Employee Signature: _____ Date: _____

Delta Dental of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
 ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(800) 356-7586.
 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-(800) 356-7586.