



# 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

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

## DEPENDENT INFORMATION

### First Name Only

If last name differs, please indicate in "other remarks" below.

Date  
of Birth

Relationship

Check box if full-time student over 19. Group must have student rider.

**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. \_\_\_\_\_

**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. \_\_\_\_\_

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 \_\_\_\_\_