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DELTA DENTAL

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 (mo/day/year)	☐ Male ☐ Female

Mailing Address (PO Box or RR)	City, State, Zip

Telephone #:	Date Employed Full-time:	# Hours Worked/Week:	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ 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)		Date of Birth (mo/day/year)
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ 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, 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: ______