DELTA DENTAL

(Please keep a copy for your records)

Enrollment/Change Form

Check One:

- ☐ New Application for Coverage
- ☐ Change Authorization
- ☐ Waiver of Coverage (complete Section (6) ONLY)

Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)

Add ☐ Terminate ☐	Social Security / ID Number:	Group Number: 54528-0-1-0	Employer/Group Name: (Please do not abbreviate) TruCare Nursing

Employee Name: (First, Middle Initial, Last) — Male ☐ Female ☐

Home Address:	City:	State:	Zip Code:	Birth Date: (mm/dd/yy)

Email Address:

By providing your email address, you agree to receive benefit information, including explanation of benefits online. We value your privacy and use a variety of security measures to protect your personal information. Your email will not be sold or used in any way except for Delta Dental communications. You may change your consent at any time, or request paper documents, by going to the Subscriber Connection section of our website. There are no conditions, consequences or fees for withdrawing your consent. You have the right to receive your documents in paper form. If you receive electronic documents, you will need access to hardware and software that supports Internet Explorer 7 or Firefox. Additionally, either your web browser or a suitable plugin for opening a file in portable document format such as Adobe Reader is required. You may update your electronic contact information by calling Customer Service at 800.234.3375, emailing moreinfo@deltadentalks.com or logging into the Subscriber Connection at www.deltadentalks.com.

Single ☐ Married ☐	Hire Date: (mm/dd/yy)	Effective Date: (mm/dd/yy)	Type of Medical Coverage: Single ☐ Family ☐	Medical Carrier and Address:

Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)

Action:	Effective Date:	Spouse Name: (First, Middle Initial, Last)		Birth Date:
Add ☐ Terminate ☐	(mm/dd/yy)		Male ☐ Female ☐	

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:

Action:	Effective Date:	Dependent Name: (First, Middle Initial) (Last Name, if different)	Male	Female	Birth Date:
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	

Section 3 OTHER INSURANCE INFORMATION: (Complete ONLY if requesting coverage for dependent[s])

	Spouse	Children
Are your dependents covered by another dental plan?	☐ Yes ☐ No	☐ Yes ☐ No
Are your dependents covered by another medical plan?	☐ Yes ☐ No	☐ Yes ☐ No

If YES, please provide spouse's Social Security #:_____

Spouse's employer:_____

Dental Carrier:

Address:

Medical Carrier:

Address:

Section 4 CHANGES: (Please mark all appropriate boxes that apply to change[s] you wish to make)

DELTA DENTAL OF KANSAS MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT

DATE OF EVENT:_____

☐ Name Change: From:_____ To:_____

☐ Marriage ☐ Divorce ☐ Adoption/Legal Custody of Child ☐ Loss of Coverage ☐ Other:_____

Section 5 SIGNATURE / AUTHORIZATION:

I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.

Authorization/Signature for Enrollment/Change[s]:_____ Date:_____

Section 6 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)

This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer, and I have decided that I:

☐ **Do not** want dental coverage for myself because:_____.

☐ **Do not** want dental coverage for my spouse and/or my children.

I understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage:_____ Date:_____

Printed-Employee Name: (First, Middle Initial, Last) _____ Social Security #:_____