DELTA DENTAL®

ENROLLMENT/CHANGE FORM

Delta Dental

Delta Dental
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deltadentalins.com

VERY IMPORTANT — Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
22518		NY

Effective Date ___/___/___ Hire Date ___/___/___

Name of Employer: Schuylerville Central School District

Location | Pay Code | Benefit Package

Enrollee/Change Information

- ❑ New Enrollment
- ❑ Marital Status Change
- ❑ Terminate Enrollee Coverage
- ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received
- ❑ Add/Delete Dependent
- ❑ Address Change
- ❑ Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Non-binary ❑ Male ❑ Female	❑ Single ❑ Married

First Name | Last Name | Middle Initial

Mailing Address (Street) | City | State | ZIP Code

Email Address (internal use only) | Phone Number ( ) - | Phone Type ❑ Cell ❑ Work ❑ Home

Name of Other Dental Carrier | Policy Holder Name (first/last) | Date of Birth / /

Effective Date of Other Policy / / | Policy Holder Street Address | City | State | ZIP Code

Enrollee Classification

- ❑ Full-Time ❑ Hourly ❑ Certified
- ❑ Part-Time ❑ Salaried ❑ Classified
- ❑ Retired ❑ Member/Other _____

COBRA (if applicable)

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce/Legal Separation*
- ❑ Widowed/Surviving Dependent*
- ❑ Dependent Child No Longer Eligible*

Indicate qualifying date: ___/___/___

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided**.

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Non binary/ Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Enrollee _____ Date ___/___/___