Delta Dental of Kentucky

ENROLLMENT & CHANGE FORM

☐ **NEW HIRE ENROLLMENT** *Hire date required below.*
☐ **OPEN ENROLLMENT**
☐ **STATUS CHANGE** *Complete Status Change information.*
☐ **COBRA** ________________ *COBRA effective date.*

EMPLOYEE INFORMATION

Social Security Number	Name – Last	First	MI	Birthdate

Home Address – Number and Street	City	State	Zip	Group Number

Gender (Circle one) M or F	Employer Name	**Hire Date Required for New Hire Enrollment**	Section Number

Phone Number	Email Address

DENTAL OPTIONS - Please select dental option and contract type.

Employee must be enrolled for members to be eligible for coverage.

☐ **Delta Dental PPO Plus Premier™**

☐ **Single** ☐ **Employee and Spouse** ☐ **Employee and child** ☐ **Employee and children** ☐ **Family**

MEMBER INFORMATION - Please list all members to be enrolled.

Last	First	MI	Date of Birth MO	DAY	YR	Sex M	F	STATUS CHANGES ONLY (Circle one)
Spouse								ADD DELETE
Dependent								ADD DELETE
Dependent								ADD DELETE
Dependent								ADD DELETE
Dependent								ADD DELETE

STATUS CHANGES ONLY

Qualifying Event - Required: ______________________________ **QE Effective Date:** ______________

If adding/deleting members, please list them in the MEMBER INFORMATION section above and indicate change in shaded area.

Terminate Subscriber's Contract as of ______________________________

Name Change: **Previous Name:** ____________________ **New Name:** ____________________

Address Change: ______________________________

READ THE PROVISIONS ON THE BACK OF THIS ENROLLMENT FORM CAREFULLY BEFORE SIGNING.
PLEASE REVIEW YOUR ENROLLMENT FORM FOR ERRORS OR OMISSIONS.

I acknowledge I have read the provisions on the back of this enrollment form and I expressly accept such provisions as a condition of coverage. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Delta Dental in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). If accepted, this form, the member certificate, the identification card, and the group contract will constitute the contract.

Signature ____ Date ____________________

Please make a copy for your records and return original to your Human Resources Director.

® Registered Mark of Delta Dental Plans Association.

ENROLLMENT FORM FOR GROUP COVERAGE

In consideration of the acceptance of this enrollment form, I represent and agree for myself and my dependents that:

1. My coverage, and that of any dependents, will become effective on the date established by my dental contract (referred to as “Plan”). I agree to be bound by the provisions of the Group Contract(s) and Certificates of Coverage issued to me. Any dependents who are later added to my Plan may have different effective dates.
2. If I have selected the DeltaCare plan, my coverage provides for coordination of covered services through a designated Primary Care Dentist and benefits for services covered under the program will be provided only when furnished by the participating dentist. I also understand that no benefits are available under this coverage if I or any dependents fail to receive services through a Primary Care Dentist.
3. If I have selected the DeltaCare plan, I am entitled to select a new Primary Care Dentist at any time during my coverage period.

   If I have selected the Delta Dental Premier or Delta Dental PPO plan, I understand that all benefits payable under my dental contract for services rendered by any participating provider will be paid to such provider. Payment for services rendered by a non-participating provider will be sent to me.
4. My employer or group administrator is authorized to deduct my share of dental premiums from my wages for 12 months and 12 month renewal periods, and is authorized to remit a premium to the Plan and to receive all notices from the Plan relating to my coverage. I understand that enrollments are by Group Contract for consecutive 12 month period(s) and my subscription fee is subject to change on the anniversary date of the Group. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period.
5. I am responsible to notify the Plan upon any change that would make me or any dependent ineligible for coverage.
6. I will cooperate with the Plan and furnish all information requested by the Plan to enforce its right of subrogation and to coordinate benefits. Subrogation is the Plan’s right to recover from a third party that may be liable to me for any injury which resulted in Dental Services paid by Plan.
7. I will reimburse the Plan for any erroneous payment and Plan may offset these amounts against future claim payments.
8. Any omitted or incorrect information or false statements made here may, at the sole option of the Plan, void or terminate my coverage or result in denial of services or benefits otherwise available hereunder for me or my dependents. I understand that if I have Delta Dental coverage on an employee paid (voluntary) plan and I terminate my coverage before the end of any 12 month enrollment period while I am still eligible to participate in the Group Contract, my benefits will be voided for the entire enrollment period, and I must reimburse my Primary Care Provider, or the Plan if the Plan has already paid the provider, at the provider’s normal fee for service, for any services or benefits received by me or my dependents during that 12 month period. I understand and agree that no agent has the authority to waive a complete answer to any question, make a determination as to applicable underwriting requirements, make or alter any contract, or waive any of the Plan’s other rights or requirements.
9. My employer, any other organization or person, any health care provider, any insurance company or insurance support agency, is hereby authorized to give the Plan any information about me and my listed dependents necessary for determining eligibility for insurance, benefits, risk classification, detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. This authorization includes any records or knowledge about my medical history, mental or physical condition, diagnosis, treatment or prognosis, including information relating to the use of drugs or alcohol. This information may also be given by the Plan to its legal representatives and reinsurers.
10. To the extent allowed by law, the Plan is authorized to furnish all information and copies of records requested by other insurers, dental plans, or other parties for the purposes of determining eligibility for coverage or benefits, exercising the right of subrogation, utilization review or audit. I give the Plan, its legal representatives or any person or organization administering claims on its behalf, permission to release to my employer or group policyholder a summary of claims incurred by me or my eligible dependents for the purpose of verifying the claims submitted under my group health plan, utilization review, or for the purpose of conducting an audit of operations or services. If my benefits are provided under a self-funded plan, the above listed parties are authorized to release any necessary information to the self-funded plan, and I understand that all information under the Plan are the property of my employer and may be retained by my employer.
11. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this application, the identification card and the group contract will constitute the contract.

PLEASE SIGN APPLICATION ON FRONT

Delta Dental of Kentucky, Inc.
10100 Linn Station Road
Louisville, KY 40223