DELTA DENTAL

(Please keep a copy for your records)

Delta Dental of Kansas Community Benefit Plan

Enrollment/Change Form

Check One:

☐ New Application for Coverage

☐ Change Authorization

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

Add ☐ Terminate ☐	Social Security / ID Number:		Employer Name:	
Applicant 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 DeltaDentalKS.com.

Single ☐ Married ☐	Effective Date: (mm/dd/yy)	Type of Coverage: Single ☐ Family ☐	

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)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	

Section 3 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

Section 4 PATIENT RESPONSIBILITIES & SIGNATURE/AUTHORIZATION

I attest that the information that I have provided is true and accurate. I understand and agree that if accepted into the program I will make an appointment with an in-network dentist, show up for all scheduled appointments, pay for any deductibles and co-payments and will keep family information updated on a timely basis (within 30 days of the event). I hereby apply for dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.

Authorization/Signature:_____ Date:_____

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