



New Application for Coverage Complete Section 1, 2, and 4.

I do not wish to enroll.

COBRA - Complete Sections 1, 2, 4 and the COBRA item in Section 3 if applicable.

Change/Subscriber Authorization Form Section 1 and 4 must be completed. Section 2 and 3, complete as applicable for change requested.

P.O. Box 8690; St. Louis, MO 63126
314-656-3000 or 800-392-1167

Group Name _____ Group#/Sublocation# - Division/Sublocation _____ If applicable:
 High Option
 Low Option

SECTION 1 EMPLOYEE INFORMATION

Employee Last Name: _____ First Name: _____ Sex: M F
Social Security No. Alternate ID Number * Birth Date (mm/dd/yyyy): ___ / ___ / ___
Street Address: _____ Coverage Effective Date: ___ / ___ / ___
City: _____ State: _____ Zip Code: _____ Check here if this is a new address.
Employee Hire Date: ___ / ___ / ___ Marital Status: Single Married Divorced Widowed

- A. Does your spouse have any other group dental coverage? Yes No
- B. If yes to A, are you covered by your spouse's plan? Yes No
- C. If yes to A, are your dependents covered by your spouse's plan? Yes No
- D. If yes to A, is the other group dental coverage through a retiree plan? Yes No
- E. If yes to B or C, provide the name of your spouse's dental plan _____

* For employer groups who utilize Alternate ID numbers, the assigned group number is the first four digits of the Alternate ID. You are still required to submit your SSN on the application for claims processing purposes.

SECTION 2 SPOUSE AND DEPENDENT INFORMATION

Please complete for spouse/dependents to be enrolled or cancelled. Use a 2nd form for additional dependents if needed.

<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Spouse - Last Name _____ First Name _____ Birth Date (mm/dd/yyyy): ___ / ___ / ___	Sex M F <input type="text"/> <input type="text"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Dependent #1 - Last Name _____ First Name _____ Birth Date (mm/dd/yyyy): ___ / ___ / ___ Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Other _____	M F <input type="text"/> <input type="text"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Dependent #1 - Last Name _____ First Name _____ Birth Date (mm/dd/yyyy): ___ / ___ / ___ Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Other _____	M F <input type="text"/> <input type="text"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Dependent #3 - Last Name _____ First Name _____ Birth Date (mm/dd/yyyy): ___ / ___ / ___ Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Other _____	M F <input type="text"/> <input type="text"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Dependent #4 - Last Name _____ First Name _____ Birth Date (mm/dd/yyyy): ___ / ___ / ___ Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Other _____	M F <input type="text"/> <input type="text"/>

IMPORTANT: For court ordered dependents, legal documentation must be attached. If your dependent meets the qualifications for full-time student status, necessary documentation is required.

SECTION 3 COVERAGE TYPE SELECTION/REASON FOR CHANGE

Select appropriate coverage type:

- Employee Only Coverage
 Employee and Spouse
 Family
 Employee and Child/Children

Name Change:

From: Last Name: _____ First Name: _____

To: Last Name: _____ First Name: _____

Reason for Change: *All changes must be made within 31 days of the qualifying event.*

Additions:

Effective Date of Addition: ___ / ___ / ___

- Birth
 Marriage
 Adoption (attach legal documentation)
 Court ordered dependent (attach documentation)
 Annual Open Enrollment
 Other (describe) _____

Cancellations:

Effective Date of Cancellation: ___ / ___ / ___

- Death
 Employee terminated on ___ / ___ / ___
 Divorce
 Dependent reached student/dependent maximum age
 Retired

Transfer Membership: Effective Date of Transfer ___ / ___ / ___

From: Group#/Sublocation# [][][][]-[][][][]
 Division/Sublocation _____

To: Group#/Sublocation# [][][][]-[][][][]
 Division/Sublocation _____

COBRA Membership: If new COBRA participant was previously covered as a dependent of another membership, please list that covered employee's social security number and name:

Social Security No. [][][][][][][][][]
 Last Name: _____
 First Name: _____

SECTION 4

I represent that the information I have provided on this form is complete and accurate. I request the group coverage to which I am entitled, or may become entitled, under the provision of the Membership Certificate/Master Policy issued by Delta Dental of Missouri. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this membership. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I also authorize any dentist or other provider of care to furnish Delta Dental of Missouri any necessary information regarding care or treatment of myself or any covered dependents. I understand that courses of dental treatment which began before my effective date may not be covered. Please note that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract.

Employee's Signature: _____ Date: _____

No action requested can be taken without your signature above.