DELTA DENTAL®

Please send completed, signed application to:
Email: eligibility@deltavisionmo.com &
GROUPACCOUNTS-DDPMO@deltadentalmo.com

Mail: P.O. Box 8690, St. Louis, MO 63126
Delta Dental: 800-392-1167 www.deltadentalmo.com
DeltaVision: 877-488-5130 www.deltavisionmo.com

DeltaVision®

Dental and Vision Benefits Enrollment/Change Application

PLEASE PRINT AND COMPLETE ALL SECTIONS.

☐ New applicant for coverage – complete sections 1, 2, 3 and 5.

☐ I do not wish to enroll.

☐ COBRA – complete sections 1, 2, 3, 4 and 5.

☐ Change/Subscriber Authorization Form – Section 1, 4 and 5 must be completed. Complete sections 2 and 3 as applicable for change requested.

SECTION 1 – EMPLOYEE INFORMATION

Group Name	Group # / Sublocation #	Division/Store Location	If applicable: Dental: ☐ High Option ☐ Low Option Vision: ☐ High Option ☐ Low Option
Employee Last Name		**First Name**	**Sex** ☐ M ☐ F
Social Security Number	**Date of Birth** (mm/dd/yyyy) ___ / ___ / _______	**Coverage Effective Date** (mm/dd/yyyy) ___ / ___ / _______	
Street Address			
City	**State**	**Zip Code**	☐ Check here if new address
Employee Hire Date (mm/dd/yyyy) ___ / ___ / _______	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed		

SECTION 2 – SPOUSE AND DEPENDENT INFORMATION

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

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.

Level of Coverage:

☐ **Dental**: ☐ Employee Only ☐ Employee and Spouse ☐ Family ☐ Employee and Child(ren)

☐ **Vision**: ☐ Employee Only ☐ Employee and Spouse ☐ Family ☐ Employee and Child(ren)

Vision Plan	Dental Plan	Last Name	First Name	Relationship	Date of Birth (mm/dd/yyyy)	Sex
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel			☐ Spouse	___/___/___	☐ M ☐ F
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel			☐ Dependent ☐ Other ________	___/___/___	☐ M ☐ F
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel			☐ Dependent ☐ Other ________	___/___/___	☐ M ☐ F
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel			☐ Dependent ☐ Other ________	___/___/___	☐ M ☐ F
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel			☐ Dependent ☐ Other ________	___/___/___	☐ M ☐ F
☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel			☐ Dependent ☐ Other ________	___/___/___	☐ M ☐ F

Continued on next page. **No action requested can be taken without your signature.**

SECTION 3 COORDINATION OF BENEFITS

Dental Coverage:

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 dental coverage through a retiree plan? ☐ Yes ☐ No

E. If yes to B or C, provide the name of your spouse's dental plan _____

F. Are your dependents covered by a dental plan other than your spouse's? If so, list the policyholder's name and the carrier.

_____

NOTE: Delta Dental does not currently obtain coordination of benefits information for its vision plans.

SECTION 4 CHANGE OF COVERAGE

Coverage change:

☐ **Dental**: ☐ Employee Only ☐ Employee and Spouse ☐ Family ☐ Employee and Child(ren)

☐ **Vision**: ☐ Employee Only ☐ Employee and Spouse ☐ Family ☐ Employee and Child(ren)

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 legal documentation)
☐ Open enrollment
☐ Other (describe) _____

Cancellations:

Effective date of cancellation: ___ / ___ / _____

☐ Death
☐ Employee terminated on ___ / ___ / _____
☐ Divorce
☐ Dependent reached student/dependent maximum age
☐ Retired
☐ Other (describe) _____

Transfer membership:

Transfer effective date: ___ / ___ / _____

From: Group # / Sublocation #: _____ Division / Store Location: _____

To: Group # / Sublocation #: _____ Division / Store Location: _____

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 Number: _____

Last Name: _____ First Name: _____

SECTION 5 EMPLOYEE AUTHORIZATION

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 my group's contract or the Membership Certificate/Master Policy issued to me. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my group 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, Advantica Insurance Company, Advantica and any of their contractors, with any necessary or requested information regarding care or treatment of myself or any covered dependents. I understand that courses of dental or vision treatment which began before my effective date may not be covered. I understand that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract and/or Membership Certificate/Master Policy. I understand that if my group has purchased an insured dental or vision product, the insured dental product is underwritten and administered by Delta Dental of Missouri, and the insured vision product is underwritten by Advantica Insurance Company and administered by Delta Dental of Missouri and Advantica Administrative Services, Inc. I understand that if my group has purchased dental or vision administrative services only, the dental administrative services are provided by Delta Dental of Missouri and the vision administrative services are provided by Delta Dental of Missouri and Advantica Administrative Services, Inc.

_____ ___ / ___ / _____

Employee Signature Date

No action requested can be taken without your signature above.