DELTA DENTAL®

Enrollment/Change Form

Delta Dental of South Dakota
P.O. Box 1157
Pierre, SD 57501 (605) 224-7345 (800) 627-3961

Effective Date:
Hire Date:

Employee Name: _____ SSN: _____

Employee Address: _____ DOB: _____

City/State/Zip: _____ Sex: _____

Group Name: _____ Group Number: _____

Marital Status: Single_____ Married_____ Divorced____ Widowed____

Does spouse have a dental plan? Yes _____ No _____

If yes, Spouse's Employer _____ Spouse's Dental Carrier _____

*List Names of Eligible Dependents:

Last Name (if different) First MI Sex Birth date

(spouse) _____

(children) _____

_____

_____

_____

_____

_____

CHANGE in Marital Status or Coverage:

Marriage Date: _____ Divorce Date: _____ Other (Explain): _____

**Signature: _____ Date: _____

*I understand that should I decide to apply for single coverage only even though I am eligible for family coverage, any subsequent application would be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Care Benefits, which may require additional limitations and waiting periods. I also understand the Delta Dental Plan of South Dakota reserves the right to reject such application.

**I accept the insurance provided by my employer's group dental plan and authorize deductions from my earnings for the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required. I understand that by accepting insurance, I am required to remain enrolled as a covered employee until the next open enrollment period or until the termination of my employment.

This plan's administration of Coordination of Benefits allows those benefits of the secondary plan plus those of the primary plan may not exceed 100% of the allowable expenses.