DELTA DENTAL

Delta Dental of Oregon & Alaska

Enrollment application & change of information form

Dental (100+)

Delta Dental use only

Group number _____

Subscriber number _____

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. *If the application is incomplete or additional information is required, your effective date may be delayed.*

Section 1 › Application type

Outside of the open enrollment period, you would need a special enrollment reason to enroll or make changes (for example, add dependents or switch plans). If you are enrolling or making changes due to a special enrollment event, please specify the event below and provide documentation of your life event. The reason I am applying or making a change is:

Open enrollment

Date of event: _____ / _____ / _____

- ☐ New policy/subscriber
- ☐ Add dependent on existing plan
- ☐ Plan change only
- ☐ *Waiver of coverage (see Section 7)*

Changes *(these can be made outside of open enrollment)*

- ☐ Name change
  New name: _____
  Old name: _____
- ☐ New address
  (please write new address in Section 3)

Special enrollment

Date of event: _____ / _____ / _____

- ☐ Marriage
- ☐ Registration of domestic partner (RDP)
- ☐ Birth, adoption or placement for adoption
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or registered domestic partnership (RDP)
- ☐ Involuntary loss of group coverage
- ☐ COBRA/continuation ended due to exhausting benefit
- ☐ Other _____

Section 2 › Coverage

- ☐ **Dental coverage**
  - ☐ Delta Dental

Group name	Subgroup	Group no.	Class
Crook County			

Section 3 › Employee information

First name*	M.I.	Last name*	Social Security no.*	
Mailing address*		City*	State*	ZIP*
Home phone	Date of birth *(mm/dd/yyyy)**	Gender* ☐ M ☐ F	Date of employment *(mm/dd/yyyy)**	
Primary language ☐ English ☐ Spanish ☐ Other _____		Email address		

Section 4 › Dependent children eligibility information

Children are eligible to enroll for coverage through age 25. Please see your Member Handbook for additional eligibility information. The following are eligible dependent children:

- Your or your spouse's natural or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- Children related by blood or marriage for whom you are the legal guardian (you will need to attach a signed court order showing legal guardianship)
- Your domestic partner's natural child or adopted child (if domestic partners by affidavit can enroll in your employer's plan)
- Your registered domestic partner's natural child or adopted child

** Enrollment will be delayed if fields with an asterisk are not filled out.*

moda

Section 5 › Dependents

Relationship code: **SP** = spouse, **DP** = domestic partner, **RDP** = registered domestic partner *(DP and RDP only if applicable to your plan)*
Please use additional form if needed.

Add	Term	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Gender*	Relationship*	Primary language *(if different from employee)*
☐	☐					☐ M ☐ F	☐ SP ☐ DP ☐ RDP	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	☐ Child[1] ☐ Ward	

Section 6 › Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No

Section 7 › Waiver of coverage information

Please include the names of all eligible members who will NOT be enrolling. *Please use additional form if needed.*

Person waiving	Reason for waiver	Health plan name	Policy no.	Employer group name
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			

Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.* In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or placement for adoption.

** If prior coverage was under Medicaid or a children's health insurance program (CHIP) you must request enrollment within 60 days after the coverage ends.*

Section 8 › Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (people who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.[2] Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding HIV/AIDS, psychotherapy notes, alcohol/drug and genetic testing. A separate authorization will be used for information related to these health conditions.
It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of health coverage.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all fields with an asterisk are not filled out entirely.

Employee signature*	Signature date*
X	

** Enrollment will be delayed if fields with an asterisk are not filled out.*
1 Please list only eligible dependent children. See Section 5 for dependent children qualifications.
2 For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-952-5033.