ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

PLEASE KEEP A COPY FOR YOUR FILES.

Please note that completing this form does not guarantee coverage.

DELTA DENTAL®

Completed forms must be returned to Brethren Insurance Services **WITHIN 31 DAYS OF YOUR HIRE DATE**. If you miss the initial 31-day enrollment period, you may be eligible for late enrollment for life and/or disability coverage. Also, keep in mind that we offer an annual open enrollment for our dental, vision, life and AD&D, long- and short-term disability, and accident plans.

ALL GROUPS MUST COMPLETE THIS SECTION

Note: Incomplete forms will be returned.

Delta Dental Group Number 10989 Church Code (if applicable)_____ ☐ Hourly ☐ Salaried

Effective Date_____ Date of Hire_____ OR Date of Rehire_____ ☐ Other_____

Name of Employer_____ Annual Salary_____

ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS

Please check one of the options below.

☐ **Yes**, I want to enroll in the dental plan offered by Delta Dental of Illinois. (Please select an option below.)

Delta Dental PPO/Delta Dental Premier ☐ Option 1 ☐ Option 2 ☐ Option 3

Social Security Number _____ Employee's Name _____
(First Name / MI / Last Name)

Mailing Address _____
(Street / City / State / ZIP)

Phone Number _____ Marital Status: ☐ S ☐ M ☐ Other Date of Birth ____/____/____ ☐ Male ☐ Female

REASON FOR SUBMITTING THIS FORM

Reinstatement Due to Qualifying Event? ☐ Yes ☐ No If yes, please describe _____

☐ Open Enrollment

☐ New Employee ☐ Reinstatement ☐ Change If this is for a change, what is the reason? _____

☐ Address Change ☐ Termination (Reason: _____) Termination Date ____/____/____

☐ Add Dependent Coverage (List Dependents below)* (Reason:_____) Date of Event ____/____/____

☐ Drop Dependent Coverage (List Dependents below)* (Reason: _____) Date of Event ____/____/____

*If you are adding or dropping a dependent due to a qualifying event, please describe:_____

☐ Name Change (Former Name: _____)

COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & One Child ☐ Employee & Children ☐ Entire Family

Effective Date: ____/____/____ Does spouse have a dental plan? ☐ Yes ☐ No Are dependents covered by spouse's plan? ☐ Yes ☐ No

Spouse's Employer:_____ Spouse's Carrier:_____

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED (Child up to age 26)

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (M/D/Y)	SEX (M or F)	SSN
		1. Spouse:				
		2. Child:				
		3.				
		4.				
		5.				

I agree to continue enrollment until canceled due to IRS-qualifying event or canceled by me during annual open enrollment. I further authorize applicable payroll deduction, where available, for premiums due.

Signature of Employee:_____ Date:_____

Signature of Employer:_____ Date:_____

CHURCH OF THE BRETHREN INSURANCE SERVICES

A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.

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