

State Of Delaware Office Of Pensions Dental Application



Effective Date

M	M	D	D	Y	Y	Y	Y

Please check the applicable box or boxes.

<input type="checkbox"/> New enrollment	<input type="checkbox"/> Name Change	<input type="checkbox"/> Change of dependents
<input type="checkbox"/> Coverage Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Termination

Please select who coverage is for: Please select one dental plan of your choice:

<input type="checkbox"/> Employee	<input type="checkbox"/> Delta Dental #1260-0001
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Dominion Dental #15339- <i>*Must provide Dentist</i>
<input type="checkbox"/> Employee & Child(ren)	
<input type="checkbox"/> Family	

NOTE: INCOMPLETE INFORMATION ON THIS FORM WILL DELAY YOUR ENROLLMENT. PLEASE PRINT CLEARLY.

Social Security Number	Employee Name (Last, First, Middle Initial)	Date of Birth
Home Address		Home Phone
City	State	Zip Code
		Work Phone
Date of Marriage	Marital Status Single Married/Civil Union Widowed Divorced Separated	
Agency PENSION OFFICE	<small>*Relationship of Spouse applies to Spouse or Civil Union Spouse *Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)</small>	

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT

Last Name	First Name	MI	Sex	Date of Birth	Social Security	*Primary Care Dentist Name	*Primary Care Dentist Code
Self							
Spouse							
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped							
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped							
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped							

IMPORTANT : Do you or your dependent(s) have other Group Dental Coverage? YES NO
If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
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Employee's Signature _____ Date _____