DELTA DENTAL

ENROLLMENT/STATUS CHANGE FORM

☒ **Delta Dental Premier** ☒ **Delta Dental PPO** ☒ **Delta Dental PPO Plus Premier** ☐ **DeltaCare**

Delta Dental Premier, Delta Dental PPO and Delta Dental PPO Plus Premier are offered by Delta Dental of Kentucky, Inc. *DeltaCare is offered by Dental Choice, Inc.*

☐ **OPEN ENROLLMENT** ☐ **NEW ENROLLMENT** ☐ **STATUS CHANGE** ☐ **COBRA**_____

Complete Status Change information below. *COBRA effective date.*

☐ **DECLINE**: I decline coverage for myself and any dependents. _____

Employee signature to decline dental coverage.

Social Security Number	Name – Last First MI			Birthdate *(mm/dd/yyyy)*
Home Address – Number and Street	City	State	Zip	Group Number 703370
Sex ☐ Male ☐ Female	Employer Name Kentucky Wesleyan College		Hire Date *(mm/dd/yyyy)*	Section Number 4001

Check the type of contract and list all members:

☐ **Single** ☐ **Employee and Spouse** ☐ **Employee and child** ☐ **Employee and children** ☐ **Family**

MEMBERS Please list all dependents below, if applicable. If additional space is required, attach a list to this form.

Last First MI	Date of Birth MM DD YYYY	Sex M	Sex F	STATUS CHANGES ONLY	Does member have other dental coverage? If so, give insurance company name and telephone number, policyholder's name and identification number.
Spouse		☐	☐	☐ ADD ☐ DELETE	
Dependent		☐	☐	☐ ADD ☐ DELETE	
Dependent		☐	☐	☐ ADD ☐ DELETE	
Dependent		☐	☐	☐ ADD ☐ DELETE	
Dependent		☐	☐	☐ ADD ☐ DELETE	

STATUS CHANGES ONLY (Complete all that apply. Qualifying event required.)

Indicate new contract type below and add or delete dependents in MEMBERS grid above:

☐ **Single** ☐ **Employee and Spouse** ☐ **Employee and child** ☐ **Employee and children** ☐ **Family**

Qualifying Event: _____ **QE Effective Date:** _____

Terminate Subscriber's Contract as of _____

_____

Name Change: Previous Name: _____ **New Name:** _____

Address Change: _____

SHADED AREA FOR OFFICE USE ONLY

Effective Date	Process Date	Processed By

READ THE PROVISIONS ON THE BACK OF THIS ENROLLMENT FORM CAREFULLY BEFORE SIGNING.
PLEASE REVIEW YOUR ENROLLMENT FORM FOR ERRORS OR OMISSIONS.

I acknowledge I have read the provisions on the back of this enrollment form and I expressly accept such provisions as a condition of coverage. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Dental Choice (DeltaCare) or Delta Dental (Delta Dental Premier and Delta Dental PPO) in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). If accepted, this form, the member certificate, the identification card, and the group contract will constitute the contract.

Signature _____ Date _____

Please make a copy for your records and return original to your Human Resources Director.

ENROLLMENT FORM FOR GROUP COVERAGE

In consideration of the acceptance of this enrollment form, I represent and agree for myself and my dependents that:

1. My coverage, and that of any dependents, will become effective on the date established by my dental contract (referred to as "Plan"). I agree to be bound by the provisions of the Group Contract(s) and Certificates of Coverage issued to me. Any dependents who are later added to my Plan may have different effective dates.

2. If I have selected the DeltaCare plan, offered by Dental Choice, Inc., my coverage provides for coordination of covered services through a designated Primary Care Dentist and benefits for services covered under the program will be provided only when furnished by the participating dentist. I also understand that no benefits are available under this coverage if I or any dependents fail to receive services through a Primary Care Dentist.

3. If I have selected the DeltaCare plan, I am entitled to select a new Primary Care Dentist at any time during my coverage period.

   If I have selected the Delta Dental Premier or Delta Dental PPO plan, offered by Delta Dental of Kentucky, Inc., I understand that all benefits payable under my dental contract for services rendered by any participating provider will be paid to such provider. Payment for services rendered by a non-participating provider will be sent to me.

4. My employer or group administrator is authorized to deduct my share of dental premiums from my wages for 12 months and 12 month renewal periods, and is authorized to remit a premium to the Plan and to receive all notices from the Plan relating to my coverage. I understand that enrollments are by Group Contract for consecutive 12 month period(s) and my subscription fee is subject to change on the anniversary date of the Group. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period.

5. I am responsible to notify the Plan upon any change that would make me or any dependent ineligible for coverage.

6. I will cooperate with the Plan and furnish all information requested by the Plan to enforce its right of subrogation and to coordinate benefits. Subrogation is the Plan's right to recover from a third party that may be liable to me for any injury which resulted in Dental Services paid by Plan.

7. I will reimburse the Plan for any erroneous payment and Plan may offset these amounts against future claim payments.

8. Any omitted or incorrect information or false statements made here may, at the sole option of the Plan, void or terminate my coverage or result in denial of services or benefits otherwise available hereunder for me or my dependents. I understand that if I have Delta Dental or Dental Choice coverage on an employee paid (voluntary) plan and I terminate my coverage before the end of any 12 month enrollment period while I am still eligible to participate in the Group Contract, my benefits will be voided for the entire enrollment period, and I must reimburse my Primary Care Dentist, or the Plan if the Plan has already paid the dentist, at the dentist's normal fee for service, for any services or benefits received by me or my dependents during that 12 month period. I understand and agree that no agent has the authority to waive a complete answer to any question, make a determination as to applicable underwriting requirements, make or alter any contract, or waive any of the Plan's other rights or requirements.

9. My employer, any other organization or person, any provider of dental care, any insurance company or insurance support agency, is hereby authorized to give the Plan any information about me and my listed dependents necessary for determining eligibility for insurance, benefits, risk classification, detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. This authorization includes any records or knowledge about my medical history, mental or physical condition, diagnosis, treatment or prognosis, including information relating to the use of drugs or alcohol. This information may also be given by the Plan to its legal representatives and reinsurers.

10. To the extent allowed by law, the Plan is authorized to furnish all information and copies of records requested by other insurers, dental plans or other parties for the purposes of determining eligibility for coverage or benefits, exercising the right of subrogation, utilization review or audit. I give the Plan, its legal representatives or any person or organization administering claims on its behalf, permission to release to my employer or group policyholder a summary of claims incurred by me or my eligible dependents for the purpose of verifying the claims submitted under my group health plan, utilization review, or for the purpose of conducting an audit of operations or services. If my benefits are provided under a self-funded plan, the above listed parties are authorized to release any necessary information to the self-funded plan, and I understand that all information under the Plan are the property of my employer and may be retained by my employer.

11. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this application, the identification card and the group contract will constitute the contract.

PLEASE SIGN APPLICATION ON FRONT

Delta Dental of Kentucky, Inc.
10100 Linn Station Road
Louisville, KY 40223