DELTA DENTAL OF IDAHO
P.O. Box 2870; Boise, Idaho 83701
(208) 489-3582

Enrollment/Change Form

☐ **Enrollment Form:** ***Complete*** **Sections I-III** ☐ **Change Form:** ***Complete*** **Sections I-IV**

I. EMPLOYEE INFORMATION (*Please Print*)

Name (First) (Middle) (Last)	Subscriber Number	Date of Birth (mo/day/yr)	☐ Male ☐ Female
Mailing Address (Street or Route)	City, State, Zip		
Telephone Number	Date Employed Full-time	No. Hours Worked/Week	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
E-mail Address	Do you want to obtain your EOB electronically? ☐ yes ☐ no • *Delta Dental of Idaho does not sell, share, rent, or lease personal information to third parties.*		

Type of Coverage: ☐ Employee ☐ Employee + Spouse ☐ Employee + One (1) Child ☐ Employee + Two (2) or More Children ☐ Employee + Spouse + One (1) Child ☐ Employee + Spouse + Two (2) or More Children

Name of Employer	***For Employer Use***	**Group Number**	**Effective Date**

II. DEPENDENT INFORMATION (List all family members you wish to enroll.)

	Relationship to Applicant	Dependent's Name	Date of Birth (mo/day/yr)	Sex	Member Number
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other	(First, MI, Last)		☐ Male ☐Female	/ /
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other)	(First, MI, Last		☐ Male ☐ Female	/ /
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other	(First, MI, Last)		☐ Male ☐ Female	/ /
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other	(First, MI, Last)		☐ Male ☐ Female	/ /
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other	(First, MI, Last)		☐ Male ☐ Female	/ /

III. OTHER DENTAL COVERAGE (Medical coverage information is not required)

Do you or your dependents have **dental coverage** under another benefit plan? ☐ Yes ☐ No *If yes, complete this section*

Name of Covered Person	Name of Covered Person's Place of Employment	Relationship to You	Date of Birth (mo/day/yr)
Name of Dental Carrier	Dental Carrier's Address	Covered Person's Group No.	Covered Person's Subscriber Number

Are you and all dependents listed above on the plan? ☐ Yes ☐No

If no, list covered dependents. ____________ ____________ ____________ ____________ ____________ ____________

IV. CHANGE REQUESTS

Change current enrollment due to: ☐Loss of previous coverage ☐Marriage ☐Divorce ☐Birth ☐Death
☐Other ______________________ Date event occurred ______________ (mo/day/yr)

Change my address to:

Change my name from: To:

I hereby apply for the group coverage for which I may be eligible, and I authorize the release of my records to Delta Dental of Idaho. I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.

Employee Signature: Date: