



Delta Dental of Oklahoma

www.DeltaDentalOK.org

Enrollment/Eligibility Update

PLAN TYPE:
(AS ESTABLISHED
BETWEEN EMPLOYER
AND DELTA DENTAL)

- DELTA DENTAL PPO - "PLUS" DELTA'S CHOICE - PREMIER
- DELTA DENTAL PPO - "POS" DELTA'S CHOICE - PPO
- DELTA DENTAL PPO DELTA DENTAL PREMIER

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS, EXPLANATION OF CODES, AND PRIVACY POLICY STATEMENT.

Employer: _____

GROUP#/SUBGROUP# LOCATION CODE

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Subscriber Information: (please complete in ink for enrollment/eligibility updates)

SUBSCRIBER NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARTIAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S
SUBSCRIBER SOCIAL SECURITY NUMBER		BIRTH DATE	FULL-TIME HIRE DATE	COVERAGE EFFECTIVE DATE		STATUS	
ADDRESS						<input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Dep. <input type="checkbox"/> Other: _____	
CITY				STATE	ZIP	CHECK HERE IF THIS IS A NEW ADDRESS <input type="checkbox"/>	

Enrollment/Eligibility Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: ____/____/____

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:		REASON FOR CHANGE:	
<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> REINSTATEMENT	<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> CHANGE IN CURRENT ENROLLMENT STATUS FOR: <input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENTS
<input type="checkbox"/> COBRA ELECTION	<input type="checkbox"/> TERMINATION OF BENEFITS		<input type="checkbox"/> DIVORCE <input type="checkbox"/> MARRIAGE <input type="checkbox"/> NAME CHANGE <input type="checkbox"/> ADOPTION/LEGAL GUARDIANSHIP*
<input type="checkbox"/> TERMINATION OF EMPLOYMENT AS OF ____/____/____		<input type="checkbox"/> OTHER _____	

GROUP TRANSFER-GROUP#/SUBGROUP# TO: GROUP#/SUBGROUP#

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*** LEGAL DOCUMENTATION MUST BE SUBMITTED FOR UPDATE/CHANGE.**

Dependent Enrollment/Eligibility Update Information: (please complete for spouse and/or dependent children for enrollment/eligibility update)

SPOUSE NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER		BIRTH DATE				
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER		BIRTH DATE		<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> DISABLED*		
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER		BIRTH DATE		<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> DISABLED*		
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER		BIRTH DATE		<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> DISABLED*		
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER		BIRTH DATE		<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> DISABLED*		

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma and acknowledge I have read the privacy policy detailed on the back of this form.

Subscriber's
Signature: _____ Date: _____

COORDINATION OF BENEFITS INFORMATION:

DOES SPOUSE HAVE A DENTAL PLAN? YES NO

ARE DEPENDENTS ENROLLED? YES NO

NAME OF OTHER CARRIER: _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or update/changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the primary subscriber. Please print clearly in ink.

Full-Time Hire Date: The date you were hired with your employer.

Coverage Effective Date: The date Delta Dental coverage takes effect for you (and/or your dependents, if enrolled).

Status Definitions (*Please select only one status*)

Active You are an eligible subscriber.

Retiree You are retired and your employer continues to provide you with dental benefits.

COBRA You are no longer an active subscriber but you have continued coverage under COBRA.
Please check with your human resources or personnel department for information regarding COBRA.

Surviving Dep. The surviving spouse or child of a deceased subscriber to whom the employer continues to provide benefits other than under provisions of COBRA.

Enrollment/Eligibility Update Information - This section should only be completed if you are: (1) enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or (3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your eligible dependents.

Reinstatement: Check for reinstatement coverage for yourself or your eligible dependents.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: Must be completed when you are transferring from one subgroup to another. (All dependents will transfer)

Dependent Enrollment/Eligibility Update Information - This section should be completed when: (1) enrolling dependents, or (2) if you are submitting updates/changes to Delta Dental enrollment. (Please include both first and last names of any individuals for whom you are enrolling or submitting an update or change).

Full-Time Student: A dependent attending full-time at an accredited school/college/university.

Disabled: Your permanently disabled dependent child. (*Requires submission of medical statement*)

Delta Dental of Oklahoma Privacy Policy

All companies part of the Delta Dental of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality. For this reason and in compliance with the Gramm-Leach-Bliley Act of 1999, Delta Dental has developed a Privacy Policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental has which may contain your confidential information..

Information We Collect - We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, our website and claims filed with Delta Dental. This information includes, for example, your name, address, social security number, date of birth and claim information. We use this information to process our Customers requests and claims, provide Customers with additional information about new products, and to comply with Federal and State Laws.

Utilization Of Information - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business to provide our Customers with services and products. We do this by allowing access to certain nonpublic personal information about our Customers and their transactions. Access to this information is restricted to individuals who require it in order to service Customer accounts or provide services to our Customers, and as permitted by law. Delta Dental reserves the right to disclose this information in these and other circumstances as allowed or required by law. HOWEVER, under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.

Our Security - We maintain physical, electronic, and procedural safeguards to protect the information we collect about our Customers. We consider this nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process.

While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers; therefore, our Customer's confidential information is protected.

If the group plan is terminated or you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at (800) 522-0188 or 405-607-2100 (in the Oklahoma City metropolitan area).
