



# Enrollment/Change Form

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

Enrollment Form: *Complete Sections I-III*

Change Form: *Complete Sections I-V*

## I. EMPLOYEE INFORMATION *(Please Print)*

Name (First) (Middle) (Last)			Subscriber Number				Date of Birth (mo/day/yr)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Street or Route)			City, State, Zip						
Telephone Number		Date Employed Full-time		No. Hours Worked/Week		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed			
E-mail Address				Do you want to obtain your EOB electronically? <input type="checkbox"/> yes <input type="checkbox"/> no <small>* Delta Dental of Idaho does not sell, share, rent, or lease personal information to third parties.</small>					
Type of Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + One (1) Child <input type="checkbox"/> Employee + Two (2) or More Children <input type="checkbox"/> Employee + Spouse + One (1) Child <input type="checkbox"/> Employee + Spouse + Two (2) or More Children									
Name of Employer				<i>For Employer Use</i>		Group Number		Effective Date	

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

<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member Number / /
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member Number / /

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, list covered dependents.</i>	_____	

## 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: _____
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