



University of Arkansas



Delta Dental Plan of Arkansas, Inc.
PO Box 15965
North Little Rock, AR 72231-5965
501-835-3400
Fax 501-992-1890
800-462-5410

DENTAL INSURANCE
ENROLLMENT APPLICATION

Entire form must be completed. Coverage subject to approval.

NEW ENROLLMENT: [] Employee [] Employee & Spouse [] Employee & Child(ren) [] Employee, Spouse & Child(ren)

CHANGE: [] ADD (circle one or both) Spouse / Child

[] TERMINATE (circle all that apply) Employee / Spouse / Child

Important Notice: If you elect to drop any portion of Dental coverage, you will not have the opportunity to add coverage again unless you do so within 31 days of a qualified change of status event. The UA does not offer an annual open enrollment period.

[] I would like to pay on a pre-tax basis. I understand that any change I need to make to my dental benefits can only take place within 31 days of a qualifying change of status event, in accordance with Section 125 regulations.

[] I would like to pay on a post-tax basis.

PART A: EMPLOYEE/SUBSCRIBER INFORMATION:

LAST NAME _____ FIRST _____ INITIAL _____ DATE OF BIRTH ____/____/____
Mo Day Year

HOME ADDRESS _____ APT# _____ PHONE NUMBER (____) _____

CITY _____ STATE _____ ZIP _____ SOC SEC NUMBER _____

MARITAL STATUS: [] Single [] Married GENDER: [] Male [] Female

DO YOU CURRENTLY HAVE OTHER DENTAL COVERAGE _____ IF YES, COMPLETE THE FOLLOWING:
(Y/N)

POLICYHOLDER'S NAME _____ NAME OF EMPLOYER _____

POLICY# _____ NAME OF CARRIER _____

PART B: DEPENDENT INFORMATION: List the eligible family members you wish to enroll/add/delete.

Table with 8 columns: Last Name, First Name, MI, Social Security Number, Date of Birth (Mo/Day/Year), Sex (M/F), Other Coverage? (Y/N). Rows include Spouse and multiple Child entries.

EMPLOYEE SIGNATURE: _____ DATE: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PART C: TO BE COMPLETED BY THE EMPLOYER:

Effective Date: _____

Campus: [] UAMS [] UALR [] UAF [] UAM [] UAPB
[] UACCB [] ASMSA [] WRC Other: _____

Group#: _____

Applicant's Hire Date _____

Original: U of A

1st copy: Delta Dental

2nd copy: Employee