University of Arkansas

DELTA DENTAL®
Delta Dental Plan of Arkansas, Inc.
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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.*

	Last Name	First Name	MI	Social Security Number	Date of Birth (Mo/Day/Year)	Sex (M/F)	Other Coverage? (Y/N)
Spouse							
Child							
Child							
Child							
Child							

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