DELTA DENTAL

Enrollment/Change Request

Employer Group Information - To be completed by Employer

Group Name	Group Number	Sublocation/Store location
amapo Indian Hills egional H.S. District	07647-00006	__/__

(A) Type of Activity - To Be Completed by Employer. Refer to instructions on back before completing this form. Print clearly.

1. Enrollment ( ) New Enrollee / Subscriber Effective Date __/__/__ Date of Hire __/__/__

2. Change - Check all that apply	Date of Event	Reason
( ) Add Spouse	__/__/__	
( ) Add Domestic Partner	__/__/__	
( ) Add Civil Union Partner	__/__/__	
( ) Add Dependent Child	__/__/__	
( ) Name Change	__/__/__	
( ) Change Plan	__/__/__	
( ) Other	__/__/__	
( ) Add/Change Office ID Numbers	__/__/__	

3. Remove or Terminate - Check all that apply	Effective Date	Reason
( ) Remove Spouse*	__/__/__	
( ) Remove Domestic Partner*	__/__/__	
( ) Remove Civil Union Partner*	__/__/__	
( ) Remove Dependent Child*	__/__/__	
( ) Employee Withdrawal/Termination	__/__/__	

NOTE: Employee must be enrolled for spouse/dependents(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Employer for available options.

Coverage for: ( ) Employee ( ) Dependents

Length of Continuation: ( ) 12 months ( ) 18 months ( ) 29 months ( ) 36 months ( ) Total Disability* Attach proof of total disability

Date of Loss of Coverage: __/__/__ Date of Qualifying Event: __/__/__

Billing: ( ) Home ( ) Group

(B) Employee Information - Complete Sections (B-G)

Last name, First name, MI _____ Social Security Number _____ Home Telephone _____

E-mail Address _____ Home Address _____ Apt # ____ City, State _____ Zip Code _____

Employer Name _____ Work Telephone _____ Work Address _____

City, State _____ Zip Code _____ Date of Employment __/__/__ Hours Worked per week _____

(C) Plan Option - Your selection must be offered by your Employer Check one: ( ) Delta Dental Premier® ( ) Delta Dental PPO ( ) Advantage Program ( ) Delta Dental PPO plus Premier ( ) DeltaCare

(D) Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. (Attach proof if full-time post-secondary student. Attach proof of disability.)

	(A) Add (C) Change (R) Remove	Last Name First Name, MI	Sex M F	Birthdate MM/DD/YYYY	Social Security Number	Other Health Coverage	Previous Coverage Check if Yes
Employee				__/__/__			
Spouse				__/__/__			
Domestic Partner (If Coverage offered)				__/__/__			
Civil Union Partner (If Coverage offered)				__/__/__			
Child				__/__/__			
Child				__/__/__			
Child				__/__/__			

(E) Other/Previous Insurance

Is your spouse/Domestic Partner/Civil Union Partner employed? ( ) Yes ( ) No If "Yes", give name and address of your spouse's employer.