DELTA DENTAL
Delta Dental of Rhode Island

P.O. Box 1517
Providence, RI 02901-1517

ENROLLMENT FORM

Please print. Complete form to ensure enrollment.

Employer Group Name	Delta Dental Group Number	Date of Hire	Location No. (if applicable)
	____-____	/ /	

Social Security No. / Subscriber I.D. No.	Subscriber Name: First (8 Characters) Last (16 Characters)
Date of Birth / /	**Street Address / P.O. Box No.**
Effective Date of Action: / /	**Apt. No.** / **City** / **State** / **Zip**

ACTION CODE (Check One) *(Changes must be made on the first of the month)*

ADDITIONS:
- ____ New Subscriber
- ____ Add Dependent to Family
- ____ Reinstatement

TERMINATION:
- ____ Remove Subscriber
- ____ Remove Dependent / Student

STATUS CHANGE:
- ____ Individual to Family
- ____ Family to Individual
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:
- ____ Reinstatement of Subscriber
- ____ Addition of Dependent — (From prior ID # _____)

DEPENDENT INFORMATION

First Name Only (If last name differs, please indicate in "other remarks" below.)	Date of Birth	Student Rider (if applicable)
Spouse		Please check box below if full-time student.
Children		☐
		☐
		☐
		☐
		☐
		☐
		☐

Type of Coverage (Check One) ☐ **Individual** ☐ **Family**

☐ **Corrections / Other Remarks** (Please Explain)_____

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ☐ No ☐ Yes **If Yes, Please Complete the Section Below.**

Other Dental Insurance Name:_____ **Type of Coverage:** ☐ Individual ☐ Family

Other Dental Insurance Address:_____

Employer Name Through Which You/Your Dependents Have Other Insurance:_____

Group Policy No.	Policy Holder Name	Policy Holder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ☐ No ☐ Yes **If Yes, Please Complete the Section Below.**

Name of Medical Insurance Company/HMO:_____ **Type of Coverage:** ☐ Individual ☐ Family

Name of Health Plan/Type of Coverage:_____

Employer Name Through Which You/Your Dependents Have Other Insurance:_____

Group Policy No.	Policy Holder Name	Policy Holder ID No.

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental of Rhode Island. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ **Date** _____ **Benefits Administrator Authorization** _____ **Date** _____