DELTA DENTAL®

EyeMed
The Eye Care Plan of America℠

ENROLLMENT/CHANGE FORM FOR SMALL BUSINESSES

Enrollment guidelines:

1. Eligible employees electing coverage for themselves must enroll following completion of their eligibility period. Employees who do not enroll **cannot enroll at a later time** unless they show proof of loss of coverage under another dental program.
2. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage under another dental program.

Delta Group Name	Delta Group Number	Name of Your Employer	Employer Number
Small Businesses			

Name _____
Last First M.I.

Social Security Number **IMPORTANT — PRINT VERY CLEARLY**
— —

Address | City | State | ZIP

A. Complete this section for new enrollment or change of status

Action requested
☐ New enrollment ☐ Change in enrollment ☐ Rehire
☐ COBRA enrollment ☐ Reinstatement ☐ SSN Correction

Date Employed ____/____/____ Month Day Year

Birthdate ____/____/____ Month Day Year

Sex ☐ Male ☐ Female

FOR OFFICE USE ONLY
Effective date of coverage _____

☐ **COBRA Enrollment**
I understand that I may be required by the employer to pay for COBRA benefits.
Note: If Dependent is enrolling under own social security number, the original Enrollee's social security number must be supplied.

— — _____
Benefits previously received under social security number (Enrollee ID Number)

Qualifying Date ____/____/____ Month Day Year

B. Complete this section for changes to existing enrollment (Complete all sections that apply)

☐ Name change ☐ Add/delete dependent ☐ Add/delete domestic partner Effective date of change ____/____/____

Reason for change _____

C. Complete this section for new dependent enrollment or to add or delete dependents

Spouse/Domestic Partner Name Last (if different) First	Add / Delete	**Sex** M F	**Birthdate** Month Day Year	**Date of Marriage** Month Day Year	
Child Name Last (if different) First	Add / Delete	**Sex** M F	**Birthdate** Month Day Year	**If child is 19 years or older** Full-time Student?*	Disabled?
				☐ Yes*	☐ Yes
				☐ Yes*	☐ Yes
				☐ Yes*	☐ Yes
				☐ Yes*	☐ Yes

***If yes, please provide proof of full-time student status**

D. Signature (Form must be signed to be processed)

I understand that I may be required to contribute up to 25% of the cost for my coverage. Additionally, I may be required to contribute up to 50% for coverage of my dependent(s). (Exception — See COBRA enrollment.) I agree to continue membership in this program during employment and while the program is in force, I agree to comply with the terms of the contract.

Employee Signature _____ Date _____

Form must be received no later than the 25th of the month prior to the desired effective date. PLEASE ALLOW AT LEAST 5 DAYS TO PROCESS.

Vision coverage by EyeMed is underwritten by Fidelity Security Life Insurance Company, 3130 Broadway, Kansas City, MO 64111 Vision Policy Form #: M-9004