

**DELTA DENTAL OF IDAHO**  
 PO Box 2870; Boise, ID 83701  
 (208) 489-3582

# Enrollment/Change Form

**Enrollment Form:** Complete Sections I-III

**Change Form:** Complete Sections I-IV

## I. EMPLOYEE INFORMATION *(PLEASE PRINT)*

Name (First)	(Middle Initial)	(Last)	Subscriber Number or SSN#	Date of Birth (mo/day/year)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Street or Route)			City, State, Zip		
Telephone #:	Date Employed Full-time:	# Hours Worked/Week:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
E-mail Address:		Do you want to obtain your EOB electronically? <input type="checkbox"/> yes <input type="checkbox"/> no		<small>Delta Dental of Idaho does not sell, share, rent, or lease personal information to third parties.</small>	
Type of Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + One (1) Child <input type="checkbox"/> Employee + Two (2) or More Children <input type="checkbox"/> Employee + Spouse + One (1) or More Children					
Name of Employer:		For Employer Use	Group Number:	Effective Date:	

## II. DEPENDENT INFORMATION *(List all family members you wish to enroll)*

Relationship to Applicant	Dependent's Name (First, MI, Last)	Date of Birth (mo/day/year)	Subscriber Number or SSN#
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female

## III. OTHER DENTAL COVERAGE *(Medical coverage information is not required)*

Do you or your dependents have **dental coverage** under another benefit plan?  Yes  No *If yes, please complete this section*

Name of Covered Person	Name of Covered Person's Place of Employment	Relationship to You	Date of Birth (mo/day/year)
Name of Dental Carrier	Dental Carrier's Address	Covered Person's Group #	

Are you and all dependents listed above on the plan? \_\_\_\_\_  
 Yes  No If No, list covered dependents. \_\_\_\_\_

## IV. CHANGE REQUESTS

Change current enrollment due to:  Loss of previous coverage  Marriage  Divorce  Birth  Death  Other \_\_\_\_\_ Date event occurred \_\_\_\_\_

Change my address to: \_\_\_\_\_

Change my name from: \_\_\_\_\_ To: \_\_\_\_\_

**I hereby apply for the group coverage for which I may be eligible, and I authorize the release of my records to Delta Dental of Idaho. I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_