DELTA DENTAL®

Eligibility Enrollment/Update

NO FORM IS REQUIRED IF WAIVING DENTAL BENEFITS

Practice Name:

Check: ☒ **Indiana** ☐ Low Option ☐ High Option

Client Name: Medical Practice Consortium Client#/Subclient#: 10120 - _____

Plan Enrollment/Update Information (*Please indicate type of update and fill in appropriate information*):

Type of Update: ☐ New Enrollment ☐ Termination of Benefits ☐ Change/Correction to Information ☐ Reinstatement

Client/Subclient Transfer
From: Client#/Subclient# **To:** Client#/Subclient#

_____ - _____ _____ - _____

Coverage Effective Date: (##/##/####) _____ / _____ / _____

Change is for: ☐ Subscriber ☐ Spouse ☐ Dependent

Subscriber Information (*Please fill in for first-time enrollments, changes or corrections*):

Subscriber Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female Status*: ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving

Social Security Number Birthdate (##/##/####) Hire Date (##/##/####) Email

_____ - _____ - _____ _____ / _____ / _____ _____ / _____ / _____

Street Address

☐ Check here if this is a new address

City State Zip Code

Spouse/Dependent Information (*Please fill in for first-time enrollments, changes or corrections*):

SPOUSE Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ Legal ☐ Surviving

_____ - _____ - _____ _____ / _____ / _____

DEPENDENT #1 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

_____ - _____ - _____ _____ / _____ / _____

DEPENDENT #2 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

_____ - _____ - _____ _____ / _____ / _____

DEPENDENT #3 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

_____ - _____ - _____ _____ / _____ / _____

DEPENDENT #4 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

_____ - _____ - _____ _____ / _____ / _____

*See reverse side for instructions.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

Subscriber's Signature: _____ **Date**: _____

INSTRUCTIONS FOR COMPLETING THIS FORM

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have questions about filling out this form, you can call (317) 261-2060 and ask to speak with the Insurance Account Manager.

Top of form

- Complete Practice Name
- Check either Low Option or High Option

Plan Enrollment/Update Information – Complete this section to request:

- New Enrollment
- Termination of Benefits (for you, dependents or both)
- Change/Correction to information (for example, change to the Low Option or High Option plan, add dependents)
- Reinstatement

Subscriber Information

- Complete this section in full

Spouse/Dependent Information

- Complete name, sex, status and birth date for each dependent you want to include on your dental policy (dependent social security numbers are not required)

Signature, Date

Be sure to sign and date the form before returning; an electronic signature is acceptable.

Mail completed form to:
ISMA Insurance Agency, 322 Canal Walk, Indianapolis, IN 46202
Scan and email to: ismaia@ismanet.org
Fax to our private insurance fax line: (317) 261-2238

NO FORM IS REQUIRED IF WAIVING DENTAL BENEFITS