

Enrollment/Change Form		Check One: <input type="checkbox"/> New Application for Coverage <input type="checkbox"/> Change Authorization <input type="checkbox"/> Waiver of Coverage (complete Section (6) ONLY)	
Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)			
Add <input type="checkbox"/>	Social Security / ID Number:	Group Number: 51576-0-1-0	Employer/Group Name: (Please do not abbreviate) U S D #263-MULVANE
Terminate <input type="checkbox"/>			
Employee Name: (First, Middle Initial, Last)		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Home Address:		City:	State: Zip Code: Birth Date: (mm/dd/yy)
Single <input type="checkbox"/>	Hire Date: (mm/dd/yy)	Effective Date: (mm/dd/yy)	Type of Medical Coverage: Medical Carrier and Address:
Married <input type="checkbox"/>	Single <input type="checkbox"/> Family <input type="checkbox"/>		
Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)			
Action:	Effective Date:	Spouse Name: (First, Middle Initial, Last)	Birth Date:
Add <input type="checkbox"/>	(mm/dd/yy)		Male <input type="checkbox"/>
Terminate <input type="checkbox"/>			Female <input type="checkbox"/>
NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:			
Action:	Effective Date:	Dependent Name: (First, Middle Initial) (Last Name, if different)	Male Female Birth Date:
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/> <input type="checkbox"/>
Terminate <input type="checkbox"/>			
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/> <input type="checkbox"/>
Terminate <input type="checkbox"/>			
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/> <input type="checkbox"/>
Terminate <input type="checkbox"/>			
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/> <input type="checkbox"/>
Terminate <input type="checkbox"/>			
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/> <input type="checkbox"/>
Terminate <input type="checkbox"/>			
Section 3 OTHER INSURANCE INFORMATION: (Complete ONLY if requesting coverage for dependent[s])			
		Spouse Children	Dental Carrier:
Are your dependents covered by another dental plan?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	Address:
Are your dependents covered by another medical plan?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	Medical Carrier:
If YES, please provide spouse's Social Security #: _____			Address:
Spouse's employer: _____			
Section 4 CHANGES: (Please mark all appropriate boxes that apply to change[s] you wish to make)			
DELTA DENTAL OF KANSAS MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT			
DATE OF EVENT: _____			
<input type="checkbox"/>	Name Change:	From: _____ To: _____	<input type="checkbox"/> Adoption/Legal Custody of Child
<input type="checkbox"/>	Marriage	<input type="checkbox"/> Divorce <input type="checkbox"/> Other:	
Section 5 SIGNATURE / AUTHORIZATION:			
I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.			
Authorization/Signature for Enrollment/Change[s]: _____			Date: _____
Section 6 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)			
This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer, and I have decided that I:			
<input type="checkbox"/>	Do not want dental coverage for myself because: _____		
<input type="checkbox"/>	Do not want dental coverage for my spouse and/or my children.		
I understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental of Kansas, Inc. and may be subject to waiting periods or limitations.			
Authorization/Signature for Waiver of Coverage: _____			Date: _____
Printed -Employee Name: (First, Middle Initial, Last) _____			Social Security #: _____