DELTA DENTAL

Eligibility Enrollment/Update

Check: ◉ **Indiana** ○ **Michigan** ○ **North Carolina** ○ **Ohio**

Client Name: Ball State University Client#/Subclient# 1008 -

Subscriber Information *(please complete for all enrollments/updates:)* Example: ABCDEF123456

Subscriber Name (Last) (First) (M.I.) Sex ○ Male ○ Female

Subscriber Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____

Status* ○ Active ○ Retiree ○ Surviving

BSU ID No.

Coverage Effective Date ___ – ___ – ____

Street Address ○ Check here if this is a new address

Email

City State ZIP Code ____ – ____

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

Type of Update: ○ New Employee ○ Add Dependent** ○ Annual OE ○ Qualifying Event** _____ ○ Termination of Benefits ○ Waive Benefits

Change is for: ○ Subscriber ○ Dependent

Type of Coverage: ○ Myself ○ Spouse ○ Child(ren) ○ Domestic Partner

Enrollment/Corrections to Information *(please fill in for spouse/dependents for first-time enrollment or corrections):*

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

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____

Status* ○ Legal ○ Surviving ○ Same Sex Domestic Partner

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

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____

Status* ○ Child ○ Disabled ○ Other

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

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____

Status* ○ Child ○ Disabled ○ Other

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

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____

Status* ○ Child ○ Disabled ○ Other

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

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____

Status* ○ Child ○ Disabled ○ Other

*See reverse side for instructions and explanation of codes.

**Include Supporting Documentation

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.

1 Subscriber's Signature_____ Date

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 any questions about filling out this form, contact The Office of Payroll and Employee Benefits.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your group continues to provide you with dental benefits.

Surviving: The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

Enrollment: Check for first time enrollment for yourself or your dependents.

Annual Open Enrollment: Check for annual open enrollment changes for yourself or your dependents

Qualifying Event: Check for changes that are being submitted on the form due to a qualifying event.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Add Dependent: Check only if you are adding a dependent to your existing coverage.

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse

Surviving: The surviving spouse or child of a deceased subscriber.

SSDP: Same Sex Domestic Partner. NOTE: Domestic Partner coverage is only available for same sex domestic partners. The employee and partner must read and sign the Affidavit of Domestic Partner Relationship.

Child: Your child or step-child.

Disabled: Your permanently disabled child.

Other: Any other dependent for whom you are legally responsible and is designated as a dependent on your Federal Income Tax Return.