DELTA DENTAL

UNIVERSITY OF ARKANSAS SYSTEM

# DENTAL INSURANCE ENROLLMENT APPLICATION

*Entire form must be completed.* ***Coverage subject to approval***

PO Box 15965
North Little Rock, AR 72231
501-835-3400
Fax 501-992-1890
800-462-5410
eligibility@ddpar.com

**NEW ENROLLMENT:** ☐ Employee ☐ Employee & Spouse ☐Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

**CHANGE:** ☐ **ADD** (circle one or both) Spouse / Child

☐ **TERMINATE** (circle all that apply) Employee / Spouse / Child

*Important Notice: If you elect to drop any portion of your Dental coverage, you will not have the opportunity to add coverage again unless you do so within 31 days of a qualified change of status event. The UA does not offer an annual open enrollment period.*

☐ I would like to pay on a **pre-tax basis**. I understand that any change I need to make to my dental benefits can only take place within 31 days of a qualifying change of status event, in accordance with Section 125 regulations.

☐ I would like to pay on a **post-tax basis.**

## PART A: EMPLOYEE/SUBSCRIBER INFORMATION:

FIRST NAME ____________________________ LAST __________________________________ INITIAL ______ DATE OF BIRTH ___/___/___
Mo Day Year

HOME ADDRESS ________________________________________________ APT # _______ PHONE NUMBER __________________________

CITY ________________________________ STATE __________ ZIP _____________ SOC SEC NUMBER __________________________

MARITAL STATUS: ☐ Single ☐ Married Gender: ☐ Male ☐ Female

DO YOU CURRENTLY HAVE OTHER DENTAL COVERAGE _____ (Y/N) IF YES, COMPLETE THE FOLLOWING:

POLICYHOLDER'S NAME ______________________________________________ NAME OF EMPLOYER _________________________________

POLICY# ________________________________________________ NAME OF CARRIER ________________________________________________

## PART B: DEPENDENT INFORMATION: *List the eligible family members you wish to enroll/add/delete.*

| | Add | Drop | Last Name | First Name | MI | Social Security Number | Date of Birth (Mo/Day/Year) | Gender (M/F) | Other Coverage? (Y/N) |
|---|---|---|---|---|---|---|---|---|---|
| **Spouse** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |

EMPLOYEE SIGNATURE: _____________________________________________________ DATE: ________________________

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## PART C: TO BE COMPLETED BY THE EMPLOYER:

Effective Date: __________________________

Campus: ☐UAMS ☐UALR ☐UAF ☐UAM ☐UAPB ☐UACCB ☐ASMSA ☒CES Other: ____________________

Group #: ___9304-2000__________________

Applicant's Hire Date: _____________________________________

UNIVERSITY OF ARKANSAS SYSTEM

DELTA DENTAL

PO Box 15965
North Little Rock, AR 72231
501-835-3400
Fax 501-992-1890
800-462-5410
eligibility@ddpar.com

# DENTAL INSURANCE ENROLLMENT APPLICATION

*Entire form must be completed.* ***Coverage subject to approval***

**NEW ENROLLMENT:** ☐ Employee ☐ Employee & Spouse ☐Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

**CHANGE:** ☐ **ADD** (circle one or both) Spouse / Child

☐ **TERMINATE** (circle all that apply) Employee / Spouse / Child

*Important Notice: If you elect to drop any portion of your Dental coverage, you will not have the opportunity to add coverage again unless you do so within 31 days of a qualified change of status event. The UA does not offer an annual open enrollment period.*

☐ I would like to pay on a **pre-tax basis**. I understand that any change I need to make to my dental benefits can only take place within 31 days of a qualifying change of status event, in accordance with Section 125 regulations.

☐ I would like to pay on a **post-tax basis.**

## PART A: EMPLOYEE/SUBSCRIBER INFORMATION:

FIRST NAME ____________________________ LAST __________________________________ INITIAL ______ DATE OF BIRTH ___/___/___
Mo Day Year

HOME ADDRESS ________________________________________________ APT # _______ PHONE NUMBER __________________________

CITY ________________________________ STATE __________ ZIP _____________ SOC SEC NUMBER __________________________

MARITAL STATUS: ☐ Single ☐ Married Gender: ☐ Male ☐ Female

DO YOU CURRENTLY HAVE OTHER DENTAL COVERAGE _____ (Y/N) IF YES, COMPLETE THE FOLLOWING:

POLICYHOLDER'S NAME ______________________________________________ NAME OF EMPLOYER _________________________________

POLICY# _________________________________________________ NAME OF CARRIER ________________________________________________

## PART B: DEPENDENT INFORMATION: *List the eligible family members you wish to enroll/add/delete.*

| | Add | Drop | Last Name | First Name | MI | Social Security Number | Date of Birth (Mo/Day/Year) | Gender (M/F) | Other Coverage? (Y/N) |
|---|---|---|---|---|---|---|---|---|---|
| **Spouse** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |
| **Child** | ☐ | ☐ | | | | | | | |

EMPLOYEE SIGNATURE: ______________________________________________ DATE: _______________________

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## PART C: TO BE COMPLETED BY THE EMPLOYER:

Effective Date: _________________________

Campus: ☐UAMS ☐UALR ☐UAF ☐UAM ☐UAPB ☐UACCB ☐ASMSA ☒CES Other: ___________________

Group #: ___9304-2000__________________

Applicant's Hire Date: __________________________________

Original: Delta Dental 1st copy: U of A 2nd copy: Employee