



Delta Dental Plan of Ohio

# Eligibility Enrollment/Update

Group Name: \_\_\_\_\_

Group#/Subgroup# -

**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  COBRA  Retiree  Surviving Coverage Effective Date --

Street Address                       Check here if this is a new address

City       State  ZIP Code --

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

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

Group Transfer From: Group/Subgroup# - To: Group/Subgroup# - Rate Code Change\* From:  To:  Effective Date of Change -- Change is for:  Subscriber  Dependent

**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

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

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

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

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

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

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

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

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

\*See reverse side for instructions and explanation of codes.

4 Subscriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_