

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM



PLEASE KEEP A COPY FOR YOUR FILES.

Please note that completing this form does not guarantee coverage.

Completed forms must be returned to Brethren Insurance Services **WITHIN 31 DAYS OF YOUR HIRE DATE**. If you miss the initial 31-day enrollment period, you may be eligible for late enrollment for life and/or disability coverage. Also, keep in mind that we offer an annual open enrollment for our dental, vision, life and AD&D, long- and short-term disability, and accident plans.

ALL GROUPS MUST COMPLETE THIS SECTION

Note: Incomplete forms will be returned.

Delta Dental Group Number 10989 Church Code (if applicable) _____ Hourly Salaried
Effective Date _____ Date of Hire _____ OR Date of Rehire _____ Other _____
Name of Employer _____ Annual Salary _____

ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS

Please check one of the options below.

Yes, I want to enroll in the dental plan offered by Delta Dental of Illinois. (Please select an option below.)

Delta Dental PPO/Delta Dental Premier Option 1 Option 2 Option 3

Social Security Number _____ Employee's Name _____
First Name MI Last Name

Mailing Address _____
Street City State ZIP

Phone Number _____ Marital Status: S M Other Date of Birth ____/____/____ Male Female

REASON FOR SUBMITTING THIS FORM

Reinstatement Due to Qualifying Event? Yes No If yes, please describe _____

Open Enrollment

New Employee Reinstatement Change If this is for a change, what is the reason? _____

Address Change Termination (Reason: _____) Termination Date ____/____/____

Add Dependent Coverage (List Dependents below)* (Reason: _____) Date of Event ____/____/____

Drop Dependent Coverage (List Dependents below)* (Reason: _____) Date of Event ____/____/____

*If you are adding or dropping a dependent due to a qualifying event, please describe: _____

Name Change (Former Name: _____)

COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family

Effective Date: ____/____/____ Does spouse have a dental plan? Yes No Are dependents covered by spouse's plan? Yes No

Spouse's Employer: _____ Spouse's Carrier: _____

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED (Child up to age 26)

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (M/D/Y)	SEX (M or F)	SSN
		1. Spouse:				
		2. Child:				
		3.				
		4.				
		5.				

I agree to continue enrollment until canceled due to IRS-qualifying event or canceled by me during annual open enrollment. I further authorize applicable payroll deduction, where available, for premiums due.

Signature of Employee: _____ Date: _____

Signature of Employer: _____ Date: _____

Delta Dental of Illinois

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CHURCH OF THE BROTHERN
INSURANCE SERVICES

A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.

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