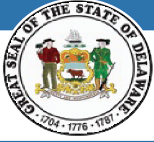

STATE OF DELAWARE
OFFICE OF PENSIONS

DENTAL APPLICATION OR REFUSAL

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Effective Date: ____________________

A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:

New Enrollment	Termination/Refusal	Change of Dependents
Coverage Change	Address Change	Name Change

B. PLEASE SELECT THE COVERAGE OPTION:

Individual	Individual & Child(ren)
Individual & Spouse	Family

C. PLEASE SELECT ONE DENTAL PLAN:

Delta Dental

Dominion Dental ***Must provide Dentist Name**

D. PLEASE COMPLETE ALL PERSONAL INFORMATION:

Pension ID or SSN:	Name (Last, First, Middle Initial):		Date of Birth:
Address:			Home Phone Number:
City:	State:	Zip Code:	Work Phone Number:

E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

Last Name	First Name	Date of Birth	SSN	Primary Care Dentist Name or Code
Self				
Spouse				
Child fulltime student disabled				
Child fulltime student disabled				
Child fulltime student disabled				

By my signature above, I hereby certify the benefit election and statements made on this form are true and my choice. I have completed the required forms necessary to enroll in the dental election noted. I understand that by completing and signing the required forms, I am affirming that any dependents noted are eligible dependents as defined by the State's Eligibility and Enrollment Rules (found on the SBO website Section 2.0). I understand this is a binding election. Once enrolled, I may not drop or change coverage during the plan year unless I experience a qualifying event that warrants the change. During the next open enrollment period, I can drop or change my dental election.

X______________________________ ______________________________
SIGNATURE **DATE**