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 COVERAGE OPTION:

Individual	Individual & Child(ren)
Individual & Spouse	Family

C. PLEASE SELECT ONE DENTAL PLAN:

- Delta Dental
- Dominion National ***Must provide Dentist Name**

D. PLEASE COMPLETE ALL PERSONAL INFORMATION:

Pension ID or SSN:	Name (Last):	Name (First):	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	Social Security Number	* Primary Care Dentist Name or Code
Self				
Spouse				
Child fulltime student disabled				
Child fulltime student disabled				
Child fulltime student disabled				

The dental plan is a **binding election**. Once enrolled, you may not drop coverage during the plan year unless you experience a qualifying event. **Please note:** ***The enrollment form is for the Pension Office's use only and will not be used for any external purpose.***

X________________________________
SIGNATURE

X________________________________
DATE

860 SILVER LAKE BLVD., SUITE 1 · MCARDLE BUILDING · DOVER, DE 19904 / SLC D570A
PHONE: (302) 739-4208 · TOLL FREE: (800) 722-7300 · FAX: (302) 739-6129 · EMAIL: PENSIONOFFICE@DELAWARE.GOV
WWW.DELAWAREPENSIONS.COM