STATE OF DELAWARE
OFFICE OF PENSIONS

DENTAL APPLICATION OR REFUSAL

PLEASE COMPLETE AND RETURN FORM TO PENSION.FORMS@DELAWARE.GOV

Effective Date: _____

A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:

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

B. PLEASE SELECT THE COVERAGE OPTION:

- ☐ Individual
- ☐ Individual & Spouse
- ☐ Individual & Child(ren)
- ☐ Family

C. PLEASE SELECT ONE DENTAL PLAN:

- ☐ Delta Dental PP)
- ☐ Dominion National DHMO*

*If you choose Dominion National DHMO, you MUST include a Dominion Dental DHMO Dentist ID and the Dentist's Name, for yourself, spouse and all eligible dependents.

D. PLEASE COMPLETE ALL PERSONAL INFORMATION:

Pension ID or SSN: _____ Date of Birth: _____

Last Name:_____ First Name: _____ MI: ___

Phone: _____ Work Phone: _____

Address: _____

City: _____State: _____Zip Code: _____

E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

Personal Information

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Spousal Information

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

*If you choose Dominion National DHMO, you MUST include a Dominion Dental DHMO Dentist ID and the Dentist's Name, for yourself, spouse and all eligible dependents.

By my signature below, 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.

_____ _____

Signature Date

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Addendum to Dental Application - Additional Dependents Information.

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____ Birth Date: _____

SSN:_____ *Dominion Dentist ID:_____ *Dentist Name:_____

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