# 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
☐ 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 PPO
☐ 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: _____

First Name & Middle Initial: _____Last Name: _____

Phone: _____ Work Phone: _____

Address: _____

City: _____State: _____Zip Code: _____

## E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

### Personal Information

First Name & Middle Initial: _____ Last Name: _____
Birth Date: _____ SSN: _____
*Dominion Dentist ID: _____ *Dentist Name: _____

### Spousal Information

First Name & Middle Initial: _____ Last Name: _____
Birth Date: _____ SSN: _____
*Dominion Dentist ID: _____ *Dentist Name: _____

### Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female
First Name & Middle Initial: _____ Last Name: _____
Birth Date: _____ SSN: _____
*Dominion Dentist ID: _____ *Dentist Name: _____

### Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female
First Name & Middle Initial: _____ Last Name: _____
Birth Date: _____ SSN: _____
*Dominion Dentist ID: _____ *Dentist Name: _____

### Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female
First Name & Middle Initial: _____ Last 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
First Name & Middle Initial: _____ Last Name: _____
Birth Date: _____ SSN: _____
*Dominion Dentist ID: _____ *Dentist Name: _____

### Dependent Information

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### Dependent Information

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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