RESET

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

☐ 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				
Fulltime ☐ Student ☐ Disabled ☐ Child				
Fulltime ☐ Student ☐ Disabled ☐ Child				
Fulltime ☐ Student ☐ Disabled ☐ Child				

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.

X _____ _____

SIGNATURE **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

SUBMIT