



State Of Delaware Office Of Pensions

Dental Application

Effective Date

M	M	D	D	Y	Y	Y	Y

Please check the applicable box or boxes.

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Name Change	<input type="checkbox"/> Change of Dependents
<input type="checkbox"/> Coverage Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Termination

Please select who the coverage is for:

Please select one dental plan of your choice:

<input type="checkbox"/> Individual	<input type="checkbox"/> Delta Dental #1260-0001
<input type="checkbox"/> Individual & Spouse	<input type="checkbox"/> Dominion National #15339 - *Must provide Dentist
<input type="checkbox"/> Individual & Child(ren)	
<input type="checkbox"/> Family	

NOTE: INCOMPLETE INFORMATION ON THIS FORM WILL DELAY YOUR ENROLLMENT. PLEASE PRINT CLEARLY.

Pension Employee ID or Social Security Number	Pensioner Name(Last, First Middle Initial)	Date of Birth
Home Address		Home Phone
City	State	Zip Code
Date of Marriage	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Civil Union <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Agency PENSION OFFICE	*Relationship of Spouse applies to Spouse or Civil Union Spouse *Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)	

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT

Last Name	First Name	MI	Sex	Date of Birth	Social Security	* Primary Care Dentist Name	* Primary Care Dentist Code
Self							
Spouse							
Child fulltime student <input type="checkbox"/> disabled <input type="checkbox"/>							
Child fulltime student <input type="checkbox"/> disabled <input type="checkbox"/>							
Child fulltime student <input type="checkbox"/> disabled <input type="checkbox"/>							

IMPORTANT: Do you or your dependent(s) have other Group Dental Coverage? YES NO

If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number

Signature _____ Date _____