Washington Court House School District

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Eligibility Enrollment/Update

Check: Michigan Indiana Ohio

Client Name:			Client#/Subclient#			
Subscriber Information (please	se complete for all enrollm	ents/updates:)	Example: ABCDEF12	23456		
Subscriber Name (Last)		(First)			(M.I.)	Sex Male
						Female
Subscriber Social Security Number	Birth Date		Status*	Coverage Effective	e Date	
			Retiree Surviving			
Street Address			Check here if this	Email		
			is a new address			
City			State	ZIP Code		
Plan Enrollment/Update Info	rmation (please indicate	type of update a	nd fill in appropriate informa	ation):		
Type of Update: 🗌 New Enrollm	ent Reinstatement	Change/Corre	ction to Information	ination of Benefits		
Group Transfer From: Client/Subclient#	To: Client/Subclient#	Rate C From:	Code Change* To: Effective Date	e of Change	Change Change	
						ndent
Enrollment/Corrections to In	formation <i>(please fill in f</i> o	or spouse/deper	idents for first-time enrollme	ent or corrections):		
SPOUSE Name (Last)		(First)			(M.I.)	Sex
						Male Female
Social Security Number	Birth Date		Status*			
			Legal Surviving			
DEPENDENT #1 Name (Last)		(First)			(M.I.)	Sex Male
Social Security Number	Birth Date		Status*			Female
			Disabled Sponsored	I		
DEPENDENT #2 Name (Last)		(First)			(M.I.)	Sex
						Male Female
Social Security Number	Birth Date		Status*			
			IRS Dep. Surviving	I		
DEPENDENT #3 Name (Last)		(First)			(M.I.)	Sex
						Male Female
Social Security Number	Birth Date		Status*			
			IRS Dep. Surviving	I		
DEPENDENT #4 Name (Last)		(First)			(M.I.)	Sex
						Male Female
Social Security Number	Birth Date		Status*			
			IRS Dep. Surviving	I		

*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

- Active: You are a current/active subscriber.
- Retiree: You are retired and your group continues to provide you with dental benefits.
- COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. Please check with your human resources or personnel department.
- Surviving: The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

Enrollment:	Check for first time enrollment for yourself or your dependents.
Reinstatement:	Check for reinstatement coverage for yourself or your dependents.
Change/Corrections:	Check if any changes are being submitted on the form.
Termination of Benefits:	Check only if you are terminating Delta Dental coverage for yourself or a family member.
Group Transfers:	When transferring from one group to another, all dependents will transfer unless otherwise indicated.

This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Delta Dental program.

Rate Codes:

- Rate 1 Employee Only
- Rate 2 Employee and spouse
- Rate 3 Employee, spouse and children
- Rate 5 Employee, one child, no spouse
- Rate 6 Employee and more than one child, no spouse

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal:	Your current spouse
Surviving:	The surviving spouse or child of a deceased subscriber.
IRS Dependent:	An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.
Disabled:	Your permanently disabled child.
Sponsored:	A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your group's contract with Delta Dental.

Delta Dental Attention: Eligibility Processing 27500 Stansbury Farmington Hills, MI 48334



DELTA DENTAL WAIVER FORM

Employee Name:			
Address:			
City:	 State:	Zip Code:	
Social Security Number:	 		
Employee Signature:			
Date:			

Note: This document waives all rights to dental coverage.

	ùr life	Enrollment F	Enrollment Form with Dependent Data	dent Data
جم , ,	Name of group (employer):			
Employee last name,	Employee last name, first name, middle initial:			
	Social Security Number:			
Gender: 🗌 male 🛛	🗌 female	Date of birth (month/date/year):	/ear):	
I	Effective Date of Coverage:			
	Type of coverage selected:	employee only		
		 employee and one dependent employee and family waive coverage 	ident	
		* Dependent Relations	* Dependent Relationship: S=spouse, C=child, H=handicapped child, T=student	sped child, T=student
dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
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	Employee Signature	- artite		

Please return this form to your benefits administrator. Do not return to VSP,

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