University of Arkansas

DENTAL INSURANCE

ENROLLMENT APPLICATION

Entire form must be completed. ***Coverage subject to approval***

DELTA DENTAL
PO Box 15965
North Little Rock, AR 72231
501-835-3400
Fax 501-992-1890
800-462-5410
eligibility@ddpar.com

NEW ENROLLMENT: ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

CHANGE: ☐ **ADD** (circle one or both) Spouse / Child

☐ **TERMINATE** (circle all that apply) Employee / Spouse / Child

Important Notice: If you elect to drop any portion of your Dental coverage, you will not have the opportunity to add coverage again unless you do so within 31 days of a qualified change of status event. The UA does not offer an annual open enrollment period.

☐ I would like to pay on a **pre-tax basis**. I understand that any change I need to make to my dental benefits can only take place within 31 days of a qualifying change of status event, in accordance with Section 125 regulations.

☐ I would like to pay on a **post-tax basis.** If neither box is checked, the current election will remain (or post-tax if new enrollment).

PART A: EMPLOYEE/SUBSCRIBER INFORMATION:

FIRST NAME _____ INITIAL _____LAST NAME_____ DATE OF BIRTH ____/____/___
Mo Day Year

STREET ADDRESS _____ APT # _____ DAYTIME PHONE NUMBER _____

CITY _____ STATE _____ ZIP _____ SOC SEC NUMBER _____

MARITAL STATUS: ☐ Single ☐ Married Gender: ☐ Male ☐ Female

DO YOU CURRENTLY HAVE OTHER DENTAL COVERAGE _____ (Y/N) IF YES, COMPLETE THE FOLLOWING:

POLICYHOLDER'S NAME _____ NAME OF EMPLOYER _____

POLICY# _____ NAME OF CARRIER _____

PART B: DEPENDENT INFORMATION: *List the eligible family members you wish to enroll/add/delete.*

	Add	Drop	First Name	MI	Last Name	Social Security Number	Date of Birth (Mo/Day/Year)	Gender (M/F)	Other Coverage? (Y/N)
Spouse	☐	☐							
Child	☐	☐							
Child	☐	☐							
Child	☐	☐							
Child	☐	☐							

EMPLOYEE SIGNATURE: _____ DATE: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PART C: TO BE COMPLETED BY THE EMPLOYER:

Effective Date: _____

Campus: ☐UAMS ☐UALR ☐UAF ☐UAM ☐UAPB ☐UACCB ☐ASMSA ☐CES Other: _____

Group #: _____

Applicant's Hire Date: _____

Original: Delta Dental 1st copy: U of A 2nd copy: Employee