DELTA DENTAL®

# Employee Legal Enrollment/Change Form

☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change

(Completed by Employer)

**Group Number** _____ **Effective Date** ___/___/___ **Department/EE Number** _____

## 1 POLICYHOLDER INFORMATION

**Name** (First, Middle Initial, Last) _____ **Social Security Number** _____

**Mailing Address** _____ **City** _____ **State** _____ **Zip** _____

**Status** ☐ Single ☐ Married ☐ Other (specify) _____ **Hire Date** ___/___/___

**Telephone** (_____)_____ ☐ Home ☐ Cell Phone **Email Address** _____

**Employer Name** _____ **Employer Location** _____

## 2 ELIGIBLE MEMBERS ELECTING COVERAGE

| List self & eligible members to be covered<br>First Name MI Last (if different) | Social Security Number | Birthdate | Sex | Full-Time College Student | Disabled Status |
|---|---|---|---|---|---|
| Self | | ___/___/___ | ☐ M ☐ F | | ☐ Yes ☐ No |
| Spouse | | ___/___/___ | ☐ M ☐ F | | ☐ Yes ☐ No |
| Eligible Child | | ___/___/___ | ☐ M ☐ F | ☐ Yes ☐ No School Name: | ☐ Yes ☐ No |
| Eligible Child | | ___/___/___ | ☐ M ☐ F | ☐ Yes ☐ No School Name: | ☐ Yes ☐ No |
| Eligible Child | | ___/___/___ | ☐ M ☐ F | ☐ Yes ☐ No School Name: | ☐ Yes ☐ No |

## 3 CHANGE OF COVERAGE

**Please check events requiring Contract changes:**

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **COBRA** ☐ **Terminating Benefits**

☐ **Other** (explain) _____ Name of Affected Party _____ Date of Event ___/___/___

## 4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

**ACCEPTANCE/WAIVER OF COVERAGE**

☐ I accept the legal coverage.

X _____ ___/___/___

Employee Signature Date

(Over, please)

## AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental"), and underwritten by ARAG Insurance Company of Des Moines, Iowa. I authorize my employer to deduct from my pay or collect from me in advance the premium therefor and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for legal coverage will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental will be entitled to declare the coverage applied for void and refuse allowance of benefits to any person thereunder.

## NONDISCRIMINATION AND ACCESSIBILITY

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.