

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

PLEASE KEEP A COPY FOR YOUR FILES

Please note that completing this form does not guarantee coverage

ALL GROUPS MUST COMPLETE THIS SECTION

Note: Incomplete forms will be returned

Delta Dental Group Number 10231 Sublocation Number 001
Date of Hire N/A OR Date of Rehire N/A
Reinstatement Due to Qualifying Event? Yes No
If yes, please describe N/A
Group Contact Doyle Rowe LTD Phone 800-564-7227 Email www.doyle Rowe.com

ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS

Please check one of the following options below.

- Yes, I want to enroll in the dental plan offered by Delta Dental Plan of Illinois.
 No, I do not want to enroll in the dental plan offered by Delta Dental Plan of Illinois.
(If you are declining, please write your name below and sign at the bottom of this form.)

Employee's Name _____ Phone Number _____ Male Female
Mailing Address _____
Soc. Sec. # _____ Date of Birth ___ / ___ / ___ Marital Status S M Other
Name of Employer IMRF Location/Department N/A
 Hourly Salaried Non-Union Other

COVERAGE DESIRED

Employee Only Employee & Spouse Employee & One Child Employee & Children Entire Family None-waive
Effective Date: ___ / ___ / ___ Does spouse have a dental plan? Yes No Are dependents covered by spouse's plan? Yes No
Spouse's Employer: _____ Spouse's Carrier: _____
Coverage will be effective on the 1st of the month following receipt of your application if received by the 25th of the month.

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (Month/Day/Year)	SEX (M or F)
		1. Spouse			
		2. Child			
		3.			
		4.			
		5.			

I agree to continue membership in this program until the next open enrollment period and authorize payroll deduction where applicable.

Signature of applicant _____ Date: _____

TO BE COMPLETED BY ADMINISTRATOR

PLAN NAME	PLAN CODE	MEMBER	PLAN CODE	SPOUSE	COVERAGE EFFECTIVE
PacifiCare Seniors Choice					
Blue Cross Blue Shield of Illinois					
Blue Cross Blue Shield of Texas					
Health Care Alliance					
Mercy Health Plan Premier Plus					
Humana Private Fee for Service					
Humana HMO					
Sav-Rx Advantage Card					
Prudential Long Term Care Plan					

	PLAN CODE _____	Member _____	Coverage Effective Date _____
Delta Dental Plan of Illinois	PLAN CODE _____	Spouse _____	Coverage Effective Date _____
	PLAN CODE _____	Family _____	Coverage Effective Date _____

	PLAN CODE _____	Member _____	Coverage Effective Date _____
Spectera Vision Care Plan	PLAN CODE _____	Spouse _____	Coverage Effective Date _____
	PLAN CODE _____	Family _____	Coverage Effective Date _____