RESET FORM PRINT

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.

☐ New enrollment	☐ Name Change	☐ Change of dependents
☐ Coverage Change	☐ Address Change	☐ Termination

Please select who coverage is for:	Please select one dental plan of your choice:
☐ Employee	☐ Delta Dental #1260-0001
☐ Employee & Spouse	☐ Dominion National #15339-*Must provide Dentist
☐ Employee & Child(ren)	
☐ Family	

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

Social Security Number	Employee Name (Last ,First, Middle Initial)		Date of Birth
Home Address			Home Phone
City	State	Zip Code	Work Phone
Date of Marriage	Marital Status ☐ Single ☐ Married/Civil Union ☐ Widowed ☐ Divorced ☐ 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 ☐ handicapped							
Child ☐ fulltime student ☐ handicapped							
Child ☐ fulltime student ☐ handicapped							

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

Employee's Signature_____Date_____