DELTA DENTAL

ENROLLMENT/CHANGE FORM - NV

Alpha Dental of Nevada, Inc.[1]

Small Business Program

Combined Dental/Vision - DeltaCare® USA[2]

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date	Hire Date

Name of Employer

❑ Add/Term/Change Due to Qualifying Event

❑ Open Enrollment

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified

❑ Retired ❑ Salaried ❑ Classified

❑ Other _____

COBRA (if applicable)

❑ Termination

❑ Reduction in Hours

❑ Divorce/Legal Separation*

❑ Widowed/Surviving Dependent*

❑ Dependent Child No Longer Eligible*

Indicate qualifying date: _____

*If a dependent is enrolling under their own social security number, the **SSN currently enrolled under must be provided**.

Enrollee/Change Information

❑ New Enrollment ❑ Marital Status Change ❑ Terminate Enrollee Coverage ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

❑ Add/Delete Dependent ❑ Address Change ❑ Other _____

Primary Enrollee Information

Social Security Number	Date of Birth	Gender ❑ Male ❑ Female ❑ Non-binary	Marital Status ❑ Single ❑ Married
First Name		Last Name	Middle
Mailing Address (Street)		City	State / Zip
E-mail Address (internal use only)		Phone Number	Phone Type ❑ Cell ❑ Work ❑ Home
Coverage type ❑ Dental ❑ Vision			
Network Facility Name		Network Facility Number	
Name(s) of Other Dental Carrier and/or Vision Carrier		Policy Holder Name (first/last)	Date of Birth
Effective Date(s) of Other Policies	Policy Holder Street Address	City / State	Zip

Dependent Information[3]

Relationship	Dependent First Name (Last only if different from enrollee)	Dental/Vision	Add/Term	Date of Birth	Male/Female/Non-binary	Disabled[4]	Network Facility Number[5]
Spouse/Partner		❑ ❑	❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑	

[1] Alpha Dental of Nevada, Inc. is the underwriter for Dental and Delta Dental Insurance Company is the underwriter for DeltaVision.

[2] DeltaCare USA is our closed network plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.

[3] Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. Primary enrollee must be enrolled in a coverage type in order to add dependents.

[4] Additional documentation, in the form of a doctor's note, will be required for disabled status.

[5] Maximum of three facilities per family.

Continue on page 2

DENTAL AND VISION

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I have been offered coverage by my employer, but at this time I wish to decline dental coverage for:

❑ Myself and my dependents ❑ Spouse/Partner ❑ Child(ren)

Reason

Required only if employee waiving dental coverage — not required if waiving coverage for dependents only

❑ Other Group Coverage Carrier Name _____ Group #_____
❑ Medicare/Medicaid provided dental coverage
❑ Individual Policy
❑ Other Reason _____ (explanation required)

❑ I have been offered coverage by my employer, but at this time I wish to decline vision coverage for:

❑ Myself and my dependents ❑ Spouse/Partner ❑ Child(ren)

Reason

Required only if employee waiving vision coverage — not required if waiving coverage for dependents only

❑ Other Group Coverage Carrier Name _____ Group #_____
❑ Medicare/Medicaid provided vision coverage
❑ Individual Policy
❑ Other Reason _____ (explanation required)

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be subject to civil fines and/or penalties.

Signature of Enrollee _____ Date _____