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 20187 Sublocation Number____ ☐ Hourly ☐ Salaried

Effective Date____ Date of Hire____ OR Date of Rehire____ ☐ Union ☐ Non-Union

Name of Employer The PANTHEOS Group Location/Department____ ☐ Other____

Group Contact Steven Swenson Phone 630-321-0133 or 877-693-9700, opt. 3 Email benefits@mypantheos.com

ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS

Please check one of the options below.

☐ **Yes,** I want to enroll in the dental plan offered by Delta Dental of Illinois. (Please select a network below.)
- ☐ Delta Dental PPO/Delta Dental Premier
- ☐ DeltaCare DHMO (If selecting DeltaCare DHMO, please complete the DeltaCare DHMO Facility Election section below.)

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

Social Security Number____ Employee's Name____ (First Name / MI / Last Name)

Mailing Address____ (Street / City / State / Zip)

Phone Number____ Marital Status: ☐ S ☐ M ☐ Other Date of Birth ____/____/____ ☐ Male ☐ Female

REASON FOR SUBMITTING THIS FORM

Reinstatement Due to Qualifying Event? ☐ Yes ☐ No If yes, please describe____

☐ Open Enrollment ☐ COBRA If COBRA, End Date ____/____/____

☐ New Employee ☐ Reinstatement ☐ Change If this is for a change, what is the reason?____

☐ Address Change ☐ Termination (Reason:____) Termination Date____/____/____

☐ Add Dependent Coverage (List Dependents below)* (Reason:____) Date of Event____/____/____

☐ Drop Dependent Coverage (List Dependents below)* (Reason:____) Date of Event____/____/____

*If you are adding or dropping a dependent due to a qualifying event, please describe:____

☐ Name Change (Former Name:____)

DELTACARE DHMO FACILITY ELECTION

If DeltaCare DHMO enrollment: Dentist Name:____ Address:____ Facility Code:____

☐ Dentist Change *(DeltaCare DHMO only):* Dentist Name:____ Address:____ Facility Code:____

COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & One Child ☐ Employee & Children ☐ Entire Family

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:____

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:____

Mail to: Eligibility Department • P.O. Box 3384 • Lisle, IL 60532 • Fax (630) 964-2997 • Email eligibility@deltadentalil.com

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