DentalandVisionIns.com

Addition or Member Address Change

Client I.D.: _____

Group Name: _____

- ○ Add New Member - Date Hired: _____-_____-_____
- ○ Add Dependents to an existing member
- ○ Address Change for a Member
- ○ Other _____

Please indicate the desired month coverage should take effect: _____
Coverage is only effective on the first of the month.

Employee Information

Social Security #: _____
We will assign an alternative identification number to be used with the provider. The alternative identification number will show on your wallet card and on the invoice for the coverage. The Social Security number will not show on any of our communications.

First Name: _____ Last Name: _____

Birth Date: MM\DD\YYYY _____ Gender: Male ○ Female ○ X ○

Address: _____

City: _____ State: _____ Zip: _____
Send Issuing Materials to: Group address Member address

Dependent Information (Please list only the dependents you wish to have enrolled)

Last Name (if different)	First	Gender (M/F/X)	Relationship	Birth Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please indicate the coverage applied for: _____

A note about waiting periods for Dental Plans
For groups of less than 10 enrolled members Delta Dental applies a 12 month waiting period for Major Services. If your group has the optional Orthodontic Benefit a 12 month waiting period also applies to the Orthodontic services.
We can waive these waiting periods with proof of continuous prior group coverage for the past 12 months. For the Orthodontic benefit waiting period to be waived the proof must also show that Orthodontia was a covered benefit with the prior coverage. Proof can consist of a Credible Coverage form from the prior carrier or an internet screen print-out from the prior carrier showing the dates of coverage and benefits.
The proof must be submitted with this enrollment form and cannot be submitted later.

I certify the above is correct and understand the coverage does not take effect until the after the application is accepted by the benefit company.

Employee's Signature _____ Date _____-_____-_____

Benefits Manager: This form is used for you to gather the information. Please go to our website and complete the online secure form to submit the request to add this member or to upload this completed form
www.DVIns.com, Click on 'Manage Your Account'

DentalandVisionIns.com

Deletion or Delete Dependents

Client I.D.: _____

Group Name: _____

◯ Delete Member and all dependents
◯ Delete listed dependents only

Coverage should stop at the end of which month: _____
Coverage is always terminated at the end of a month. Credit can only be given for the current month.

Employee Information
Identification # : _____ Name: _____

Dependent Information – List dependents only if you are just deleting dependents and keeping the employee coverage active.
Only list dependents to be deleted

Last Name (if different)	First	Relationship	Birth Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Important information about COBRA

A group is subject to Federal COBRA regulations if they had 20 or more employees on more than 50 percent of its typical business days in the previous calendar year. Both full and part-time employees are counted to determine whether a plan is subject to Federal COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.
Groups of 2 to 19 are subject to Cal-COBRA regulations. Please go to www.dvins.com, 'Manage Your Account' to report which COBRA regulations apply to your group. This may change every calendar year.
Federal COBRA groups will need to issue a COBRA form with the termination of coverage.
Members who extend coverage under Federal COBRA will have the individual premium collection done by the group and the member will show on the group invoice as COBRA. If you need a federal COBRA form, Please go to www.DOL.gov and search for model COBRA notices.

Cal-COBRA groups will need to give us the members address with the reason for termination of coverage. We will generate the Cal-COBRA election form and invoice the member directly for the coverage.

Cal-COBRA Home Address: _____

_____ Zip_____

Please indicate the reason for this termination of coverage.

- ◯ Voluntary termination of employment
- ◯ Involuntary termination of employment
- ◯ Reduction of work hours
- ◯ Social Security Disabled
- ◯ Legal Separation or Divorce
- ◯ Dependent ceasing to be eligible
- ◯ Death of Subscriber
- ◯ Active employee dropping coverage (not eligible for CA COBRA)

I certify the above is correct.

Employer's Signature _____ Date _____

Benefits Manager: This form is used for you to gather the information. Please go to our website and complete the online secure form to submit the request to delete this member or to upload this completed form
www.DVIns.com, Click on 'Manage Your Account'