P.O. Box 8 314-656-3	8690; St. Louis, MO 63126 9000 or 800-392-1167	New Application for Covera Complete Section 1, 2, and COBRA - Complete Section 1, 2, 4 and the COBRA item Section 3 if applicable.	4.  S Change/Subs	to enroll. criber Authorization Form Se e completed. Section 2 and 3 applicable for change request	,
Group Nar Pattor	nville School District	Group#/Sublocation# Division/Sublocation	3720-	☐ High Option☐ Low Option	
	SECTI	ON 1 EMPLOYEE IN	IFORMATION		<del></del>
Employee	Last Name:	First Name:		Sex:	
Social Sec	curity No.	Alternate ID Number *		Birth Date (mm/dd/yyy	y): 
Street Add	dress:			Coverage Effective D	ate:
City:		State:	Zip Code:	Check here if this new address.	s is a
Employee	Hire Date://	Marital State	us: Single Married	☐ Divorced ☐ Widow	ed
B. If yes to C. If yes to D. If yes to E. If yes to * For emp	your spouse have any other group de to A, are you covered by your spouse to A, are your dependents covered by to A, is the other group dental coverate B or C, provide the name of your soloyer groups who utilize Alternate ID till required to submit your SSN on the	e's plan? y your spouse's plan? ge through a retiree plan pouse's dental plan numbers, the assigned g	roup number is the first four	digits of the Alternate ID.	
	SECTION 2 SP	OUSE AND DEPEN	DENT INFORMATION		
Please co	implete for spouse/dependents to be	enrolled or cancelled. U	se a 2nd form for additional d	lependents if needed.	
Enroll Cancel	Spouse - Last Name	First	Name		Sex MF
	Birth Date (mm/dd/yyyy):/	/			
Enroll Cancel	Dependent #1 - Last Name	Firs	l Name		MF
	Birth Date (mm/dd/yyyy):/_	/ Rela	ationship: Child Oth	ner	
Enroll Cancel	Dependent #1 - Last Name	Firs	t Name		MF
	Birth Date (mm/dd/yyyy):/	/ Rela	ationship: Child Oth	ner	
Enroll Cancel	Dependent #3 - Last Name	Firs	t Name	,	MF
	Birth Date (mm/dd/yyyy):/	/Rel	ationship:	ner	
7 124	Dependent #4 Last Name	Fire	t Name		-ME

IMPORTANT: For court ordered dependents, legal documentation must be attached. If your dependent meets the qualifications for full-time student status, necessary documentation is required.

Relationship:

Child Other

Birth Date (mm/dd/yyyy):

Cancel

SECTION 3 COVERAGE TYPE SELECTION/REASON FOR CHANGE						
Select appropriate coverage type:						
☐ Employee Only Coverage ☐ Employee and Spouse	Family Employee and Child/Children					
Name Change:						
From: Last Name: Fi	First Name:					
To: Last Name: Fi	rst Name:					
Reason for Change: All changes must be made within 31	days of the qualifying event.					
Additions:  Effective Date of Addition: / / / Birth  Marriage  Adoption (attach legal documentation)  Court ordered dependent (attach documentation)  Annual Open Enrollment  Other (describe)  Transfer Membership: Effective Date of Transfer /	Cancellations:  Effective Date of Cancellation: / / //  Death					
From: Group#/Sublocation# Division/Sublocation	To: Group#/Sublocation# — — — — Division/Sublocation					
COBRA Membership: If new COBRA participant was previously covered employee's social security number and name Social Security No.  Last Name:						
SECTION 4						
I represent that the information I have provided on this form is completed, or may become entitled, under the provision of the Members authorize the proper deductions, if any, from my earnings as my contemployer may act as my agent under this membership. I understand payments, and I agree to repay promptly any benefit payments to wh dentist or other provider of care to furnish Delta Dental of Missouri ar any covered dependents. I understand that courses of dental treatment Please note that coverage is subject to the limitations, exclusions, and Employee's Signature:	hip Certificate/Master Policy issued by Delta Dental of Missouri. I ribution toward the cost of this coverage and agree that my that I cannot transfer my or my dependents' right to receive benefit ich I or my dependents were not entitled. I also authorize any necessary information regarding care or treatment of myself or ent which began before my effective date may not be covered.					

No action requested can be taken without your signature above.