

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: _____ First Name: _____
To: Last Name: _____ First 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) _____

Cancellations:

Effective Date of Cancellation: ___ / ___ / ___

- Death
 Employee terminated on ___ / ___ / ___
 Divorce
 Dependent reached student/dependent maximum age
 Retired

Transfer Membership: Effective Date of Transfer ___ / ___ / ___

From: Group#/Sublocation# [] [] [] [] - [] [] [] [] Division/Sublocation _____
To: Group#/Sublocation# [] [] [] [] - [] [] [] [] Division/Sublocation _____

COBRA Membership: If new COBRA participant was previously covered as a dependent of another membership, please list that covered employee's social security number and name:

Social Security No. [] [] [] [] [] [] [] [] [] Last Name: _____ First Name: _____

SECTION 4

I represent that the information I have provided on this form is complete and accurate. I request the group coverage to which I am entitled, or may become entitled, under the provision of the Membership Certificate/Master Policy issued by Delta Dental of Missouri. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this membership. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I also authorize any dentist or other provider of care to furnish Delta Dental of Missouri any necessary information regarding care or treatment of myself or any covered dependents. I understand that courses of dental treatment which began before my effective date may not be covered. Please note that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract.

Employee's Signature: _____ Date: _____

No action requested can be taken without your signature above.