



Delta Dental of Illinois Enrollment/Change of Status Form for Dental and Vision Policy

**PLEASE SEND APPLICATION TO ATTENTION: AFFINITY DEPARTMENT
P.O. BOX 3930 | PEORIA, IL 61612-9806 OR FAX: 866-817-9009**

Please type or print in black ink and complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

APPLICANT

Last Name		First Name		Middle Initial	Date of Birth __/__/__
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partnership			Social Security Number	
Applicant Status <input type="checkbox"/> Member of Association and/or Member of Trust <input type="checkbox"/> Other _____					
Mailing Address			City	State	ZIP
Phone Number ()			Email Address		
Name of Association AVMA LIFE			Association Number 20363	Sublocation Number (if applicable)	
Requested Effective Date of Coverage __/__/__					

I consent to receive Explanation of Benefits (EOBs) from Delta Dental of Illinois by Email. Yes No

I consent to receive policy and legally required communications from Delta Dental of Illinois by Email. Yes No

APPLICANT/ DEPENDENT/ ADDITIONS/ TERMINATIONS/ CHANGES

Please check two of the options below.

- Yes,** I want to enroll in the AVMA LIFE dental benefit plan offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)
 - Delta Dental PPO/Delta Dental Premier - High Plan
 - Delta Dental PPO/Delta Dental Premier - Low Plan
- No,** I do not want to enroll in the AVMA LIFE dental benefit plan offered by Delta Dental of Illinois.
- Yes,** I want to enroll in the AVMA LIFE DeltaVision** Coverage.
- No,** I do not want to enroll in the AVMA LIFE DeltaVision Coverage.

CONTINUED ON NEXT PAGE

REASON(S) FOR SUBMITTING THIS FORM

Initial or Open Enrollment

Retiree

Reinstatement due to:

Loss of Other Coverage Other _____

Qualifying Event or Add Dependent due to:

Birth Adoption/Placement for Adoption Marriage Domestic Partnership

Civil Union Legal Guardianship Loss of Other Coverage

Dependent Child with Disability Military Dependent Court Order Other _____

Date of Qualifying Event ___/___/___

Drop Dependent due to:

Age Death Divorce Other Coverage Elsewhere

Date of Qualifying Event ___/___/___

Name Change

Former Name _____ New Name _____

Address Change _____

Termination of Employment

Date ___/___/___

ENROLLMENT SELECTION

Select one for dental:

Applicant Only

Applicant Plus One Dependent Child

Applicant Plus Spouse or Domestic Partner

Entire Family

Is your spouse covered under another dental plan? Yes No

If "Yes," list the name of the carrier: _____

Please list your spouse's employer: _____

Are you and/or your dependent(s) covered by any other dental benefit program? Yes No

If "Yes," list the name of the carrier: _____

Select one for DeltaVision:

Applicant Only

Applicant Plus Child(ren)

Applicant Plus Spouse or Domestic Partner

Entire Family

CONTINUED ON NEXT PAGE

DEPENDENTS

Indicate the names of all dependents to be insured or terminated under the AVMA LIFE Policy.

Add	Delete	First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Dependent Status	Gender
				__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female
				__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female
				__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female
				__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	<input type="checkbox"/> Male <input type="checkbox"/> Female

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

DISCLAIMER: The Spanish version of this form is provided only as a courtesy to the customer. The English version of this form will be the presiding version in any case of a dispute or complaint.

DESCARGO DE RESPONSABILIDAD: La versión en español de este documento se proporciona únicamente como cortesía para el cliente. La versión en inglés de este documento constituirá la versión predominante en el caso de alguna disputa o reclamación.

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits.

Signature of Applicant	Date ____/____/____
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**DeltaVision is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.*