Delta Dental of South Dakota
PO Box 1157 Pierre, SD 57501
800-627-3961
Fax 605-224-0909
www.deltadentalsd.com

Enrollment/Change Form

Effective date: _____

Hire date: _____

Group name: _____ Group number: _____

Employee name: _____ SSN: _____

Mailing address: _____ DOB: _____

City/State/Zip: _____ Sex: _____M _____F

Cell phone* _____ Email:* _____

Marital status (common law marriage is not recognized in South Dakota): Single ___ Married ___

List only the names of dependents you are enrolling. I understand that should I decide to apply for single coverage, even though I am eligible for family coverage, I cannot change my policy until open enrollment or a qualifying event (within the past 30 days). I also understand that Delta Dental of South Dakota reserves the right to reject a change form.

First Name Last Name Gender Date of Birth

☐Add
☐Drop Spouse

Cell phone* Email*

☐Add
☐Drop Child

Cell phone* Email*

☐Add
☐Drop Child

Cell phone* Email*

☐Add
☐Drop Child

Cell phone* Email*

☐Add
☐Drop Child

Cell phone* Email*

Use an additional sheet if you have more dependents. List dependents you want removed from your plan in the space provided above.

Change in coverage

Marriage date: _____ Divorce date: _____

Other (explain): _____ Date of change: _____

Signature: _____ Date: _____

I accept the insurance provided by my employer's group dental plan and authorize deductions from my earnings for the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required. I understand that by accepting insurance, I am required to remain enrolled as a covered employee until the next open enrollment period, a qualifying event, or until the termination of my employment.

*I consent to Delta Dental using this contact information for quality improvement activities (e.g. surveys) for individuals over the age of 18.