DELTA DENTAL®

Enrollment/Change Form

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
(605)224-7345 Fax (605)224-0909
(800)627-3961
www.deltadentalsd.com

Effective Date: _____

Hire Date: _____

Group Name: Mitchell School District **Group Number:** 2088

Employee Name: _____ SSN: _____

Employee Address: _____ DOB: _____

City/State/Zip: _____ Sex: _____M _____F

Phone Number: _____ Email Address: _____

Marital Status (common law marriage is not recognized in South Dakota): Single _____ Married _____

***List only names of dependents you are enrolling:**

	First	Last (if different)	Sex	Birth Date
☐ Add ☐ Drop	SPOUSE			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			

Please use additional sheet if you have more dependents.

CHANGE in Coverage (Please list dependents you want removed from your plan in space provided above):

Marriage Date: _____ Divorce Date: _____

Other (explain): _____ Date of Change: _____

****Signature: _____ Date: _____**

*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.

**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.