

[E] Other/Previous Insurance

Is your spouse employed? YES NO If "Yes", give name and address of your spouse's employer.

If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID #.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

[F] Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? Yes No If "Yes", who and at what address?

Explain the circumstances

If any dependent's last name differs from yours, explain the circumstances.

[G] Employee Signature *If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature - Required _____ Date ____/____/____ Title _____ Date ____/____/____ Li-mail Address _____

[H] Employer Verification - To Be Completed by Employer

Employer Instructions

- Complete the Employer Group information in the upper left corner of the form.
- Section A - Type of Activity: Check boxes indicating reason(s) for submitting application.
- Complete Section [H] - Employer Verification in the upper left corner of the second page of the form.
 - Employer must complete this section for all new enrollments, coverage changes and terminations.
 - Employer must sign and date the Enrollment/Change Request in order for it to be processed.
- **Employee - Complete Sections [B-G]**
- **Section [B] - Employee Information:**
 - Complete all information in order for your application to be processed.
 - Check one: Plan Option box Delta Premier Delta Preferred Option Delta Preferred Delta Care
- **Section [D] - Individuals Covered:**
 - Select only an option offered by your employer.
 - Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
 - Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security number for each individual listed.
 - If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school certifying that dependent is continuing full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
 - If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section [F] - Other/Previous Insurance.
 - From the appropriate provider directory, locate the office ID number for the dentist (if applicable). Indicate office ID number selection(s) on the form.
- **Section [F] - Pre-Existing Conditions Statement:**
 - Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2 - 5 employees and by late entrants.
- **Section [E] Other / Previous Insurance**
 - Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section [G] - Dependent Information

- Complete this section for all new enrollments or coverage changes.
- **Section [H] - Employee Signature:**
 - Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.
- **Section [I] - Employer Verification:**
 - Employer must complete this section for all new enrollments, coverage changes and terminations.
 - Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.
- **Conditions of Enrollment**
- **Applicant Acknowledgment and Agreements**

1. On behalf of myself and the dependents listed on the reverse side I agree to or with the following:

- a) I authorize the sources stated below to give to Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional, any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
- b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 36 months, if not revoked earlier.
- c) I know that I have a right to receive a copy of the authorization if I request one.
- d) I agree that a photocopy of this authorization is as valid as the original.

2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.

3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

4. **Misrepresentation**

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.