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: Meade School District 46-1 **Group Number:** 2361

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.