

# ENROLLMENT/CHANGE FORM



P.O. Box 1809  
Alpharetta, GA 30023-1809  
1-800-521-2651  
Fax: 770-641-5393

**For Employer Use Only**

|                            |                       |
|----------------------------|-----------------------|
| Effective Date<br>/ /      | Group No <b>18113</b> |
| Full Time Hire Date<br>/ / | Sublocation           |

**Check One** (\*\*Enrollees can change plans only during open enrollment.)

- New Hire
- Open Enrollment
- Change Dental Plans\*\*
- COBRA
- Add/Delete Dependent
- Terminate Employee Coverage
- Spouse Employment Change
- Marital Change
- Other \_\_\_\_\_

Indicate qualifying date:  
 \_\_\_\_\_  
(Month) (Day) (Year)

**COBRA Enrollment Only**

- Please indicate qualifying event:
- Termination
  - Reduction in Hours
  - Divorce
  - Widowed/Surviving Dependent
  - Dependent Child No Longer Eligible

Indicate qualifying date:  
 \_\_\_\_\_  
(Month) (Day) (Year)

**Primary Enrollee Information**

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: \_\_\_\_\_  
(Last, First)

Mailing Address: \_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Name of Employer/Group **P E O P L E L E A S E** Location \_\_\_\_\_

Marital Status: Single  Married  Gender: Male  Female  Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Do you have dependent children? Yes  No  Are you or your dependents covered under another dental plan? Yes  No

**Dependent Information**

VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF  
 (If enrolling one dependent, ALL must be enrolled.)

|                  | Add                      | Delete                   | Male                     | Female                   | Date of Birth: |       |       |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|-------|-------|
| Spouse: _____    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |
| Dependent: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |
| Dependent: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |
| Dependent: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |
| Dependent: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |
| Dependent: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |
| Dependent: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |
| Dependent: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          | _____ | _____ |

- I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.
- I decline coverage at this time.

*Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

Signature of Enrollee \_\_\_\_\_

Date \_\_\_\_\_

Plan Benefit Highlights for: People Lease

Group No: 18113

Effective Date: 1/1/2023

DELTA DENTAL PPO<sup>SM</sup>

BENEFIT HIGHLIGHTS

|   |   |                             |  |                           |
|---|---|-----------------------------|--|---------------------------|
| <b>Eligibility</b>  | Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26 |                             |  |                           |
| <b>Deductibles</b><br>Deductibles waived for Diagnostic and Preventive (D & P) and Orthodontics?        | \$50 per person / \$150 per family each calendar year<br>Yes  |                             |  |                           |
| <b>Maximums</b><br>D & P counts toward maximum?   | \$1,500 per person per calendar year<br>Yes   |                             |  |                           |
| <b>Waiting Period(s)</b>  | Basic Benefits<br>None  | Major Benefits<br>12 months | Prosthodontics<br>12 months            | Orthodontics<br>24 months |
| <b>Benefits and Covered Services*</b>   | <b>Delta Dental PPO dentists**</b>  |                             | <b>Non-Delta Dental PPO dentists**</b> |                           |
| <b>Diagnostic &amp; Preventive Services (D &amp; P)</b><br>Exams, cleanings, x-rays and sealants        | 100 %   |                             | 100 %                                  |                           |
| <b>Basic Services</b><br>Fillings and simple tooth extractions  | 80 %  |                             | 80 %                                   |                           |
| <b>Endodontics</b><br>(root canals)<br>Covered Under Basic Services                                     | 80 %  |                             | 80 %                                   |                           |
| <b>Non-Surgical Periodontics</b><br>(non-surgical gum treatment)<br>Covered Under Basic Services        | 80 %  |                             | 80 %                                   |                           |
| <b>Surgical Periodontics</b><br>(surgical gum treatment)<br>Covered Under Major Services                | 50 %  |                             | 50 %                                   |                           |
| <b>Oral Surgery</b><br>Covered Under Major Services   | 50 %  |                             | 50 %                                   |                           |
| <b>Major Services</b><br>Crowns, inlays, onlays and cast restorations, denture reline/rebase and repair | 50 %  |                             | 50 %                                   |                           |
| <b>Prosthodontics</b><br>Bridges and dentures   | 50 %  |                             | 50 %                                   |                           |
| <b>Orthodontic Benefits</b><br>Dependent childrento age 19  | 50 %  |                             | 50 %                                   |                           |
| <b>Orthodontic Maximums</b>   | \$1,000 Lifetime  |                             | \$1,000 Lifetime                       |                           |
| <b>Rates are effective<br/>1/1/2023 – 12/31/2023</b>  | <b>Employee Only</b>  |                             | <b>\$41.92</b>                         |                           |
|   | <b>Employee &amp; 1 Dependent</b>   |                             | <b>\$81.93</b>                         |                           |
|   | <b>Employee &amp; Family</b>  |                             | <b>\$120.41</b>                        |                           |

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.  
\*\* Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the 90th percentile for non-Delta Dental dentists.

|  |   |   |
|--|---|---|
| <b>Delta Dental Insurance Company</b><br>1130 Sanctuary Parkway, Suite 600<br>Alpharetta, GA 30009 | <b>Customer Service</b><br>800-521-2651 | <b>Claims Address</b><br>P.O. Box 1809<br>Alpharetta, GA 30023-1809 |
|--|---|---|

**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.