



Delta Dental of Missouri

P.O. BOX 8690
ST. LOUIS, MO 63126-0690
(314) 656-3000
(800) 392-1167
(314) 656-2900

New/Application for Coverage
Complete Sections I, II & IV
Change/Subscriber Authorization Form
Sections I and IV must be completed.
Sections II and III, complete as applicable
for change requested.

I do not wish to enroll
COBRA (Complete Sections I, II & IV
and Item 18 in Section III, if applicable)

PLEASE PRINT AS YOUR I.D. CARD IS GENERATED FROM THIS FORM.

SECTION I EMPLOYEE INFORMATION

1. Social Security No. 2. Applicant's Name Last First Middle 3. Birthdate 4. Sex M F Effective Date
5. Applicant's Address: Street City State Zip Code Group Number
6. Employer/Group Name 7. Div/Class/Location/Clock No. 8. Date Employed 9. Single Married Divorced Separated Widowed
10.A Name of spouse's employer 11. A. Does your spouse have any other group dental coverage? B. Are you covered by your spouse's plan? C. Are your dependents covered by your spouse's plan?
B. Name of spouse's Dental Plan If yes to B, or C, spouse's ID #
C. Address of spouse's Dental Plan 12. Do you want your spouse covered? Do you want your children covered?

SECTION II DEPENDENT INFORMATION

(List each eligible family member you want added to, or removed from, your membership.)
(Use a second Form if necessary.)

Table with columns: Check one Add Delete, First name Middle Last, if different, Sex M/F, Relationship to member, Date of birth (mo-day-yr)

SECTION III Complete only those sections that apply to the change(s) you wish to make.

13. Change Membership Type to: Member only Member and Spouse Member and Family Member and Child/Children
14. Name Change: From To: Last first middle
15. Reason for Change(s) requested above: (ALL CHANGES MUST BE MADE WITHIN 30 DAYS OF EVENT)
Member's marriage Retired Divorce
Newborn child Child reached age limit Death
Adoptive/legal custody of child Child's marriage Group anniversary date
Other
Date event checked above occurred:
16. Cancel Membership (Effective date of coverage termination)
17. Transfer Membership
From Group No. Group Name
To Group No. Group Name
Date employed by (or date joined) the group you're transferring to:
18. COBRA Membership: If new COBRA participant was previously covered as a dependent of another membership, please list that covered employee's social security and name:
Name:

SECTION IV Read and SIGN below

I request the group coverage to which I am entitled, or may become entitled, under the provision of the Membership Certificate issued by Delta Dental Plan of Missouri (DDPM).
I authorized the proper deductions, in any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this membership. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly and benefit payments to which I or my dependents were not entitled.
I also authorize any dentist or other provider of care to furnish DDPM any necessary information regarding care or treatment of myself or any covered dependents.
I understand that courses of dental treatment which began before my effective date may not be covered, and under Coverage C, if included, replacement of bridges or dentures may not be covered during my first year of membership.

(Applicant's Signature) (Date)

No action requested can be taken without your signature above.