



# 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:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

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
<input type="checkbox"/> Add				
<input type="checkbox"/> Drop	SPOUSE			
<input type="checkbox"/> Add				
<input type="checkbox"/> Drop	CHILD			
<input type="checkbox"/> Add				
<input type="checkbox"/> Drop	CHILD			
<input type="checkbox"/> Add				
<input type="checkbox"/> Drop	CHILD			
<input type="checkbox"/> Add				
<input type="checkbox"/> Drop	CHILD			
<input type="checkbox"/> Add				
<input type="checkbox"/> 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.