DELTA DENTAL®

SMALL BUSINESS PROGRAM ENROLLMENT LIST FORM

EyeMed VISION CARE®

For New Delta Dental PPO℠ Groups Only

Employer name: _____ **Effective Date:** _____

1. Eligible employees electing coverage for themselves must enroll following completion of their eligibility period. Employees who do not enroll cannot enroll at a later time unless they show proof of loss of coverage under another dental program.
2. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees *declining* dependent coverage cannot enroll their dependents at a later time unless the dependents show proof of loss of prior coverage under another dental program.

Check one box			*For primary enrollees only*										**Note: List dependents immediately after their primary enrollee Please skip a line before entering next primary enrollee's name.**				*For dependent children only*
Primary Enrollee	Spouse	Dependent Child	**PRINT VERY CLEARLY** Primary Enrollee's Social Security #										Primary Enrollee's Date of Hire	Last Name	First Name	M/F	Date of Birth	List Status if Dependent Child is Age 19 or Older S=Student D=Disabled

Page _____ of _____ PLEASE TYPE OR PRINT LEGIBLY (Attach additional sheets if necessary)