DELTA DENTAL

DENTAL ENROLLMENT/CHANGE FORM

Fax Form to ARSEBA
(501) 663-1445
Arkansas State Employees Benefit Advisors
1301 West 7th Street, Little Rock, AR 72201
Questions? Call (501) 224-5234 or (888) 224-5233

ARSEBA
ARKANSAS STATE EMPLOYEES BENEFIT ADVISORS

AGENCY NAME:_____

For internal use only:

Delta Dental Group Number:_____

Effective Date:_____ (MM)_____(DD)_____(YY)

LAST NAME: _____ FIRST: _____ MI: _____

SSN: _____ PERSONNEL NUMBER: (employee ID) _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ EMAIL: _____

DATE OF HIRE: _____(MM)_____(DD)_____(YY) GENDER: ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____(MM)_____(DD)_____(YY) MARITAL STATUS: ☐ SINGLE ☐ MARRIED

1. COVERAGE CHANGES

*Please check the box(es) next to the reason for your change

Type of coverage selected & plan option (choose one)

Base Dental
- ☐ Employee $20.60
- ☐ Employee/Spouse $41.06
- ☐ Employee/Child(ren) $40.12
- ☐ Employee/Family $66.48

Premium Dental
- ☐ Employee $30.72
- ☐ Employee/Spouse $61.22
- ☐ Employee/Child(ren) $59.78
- ☐ Employee/Family $99.08

Monthly Rates effective January 1, 2024 – December 31, 2025

- ☐ Open enrollment
- ☐ New Hire
- ☐ Agency Change
- ☐ Term Coverage
- ☐ Status Change
- ☐ Address Change

Reason(s) for Status Change:
- ☐ Marriage*
- ☐ Divorce*
- ☐ Birth or adoption of child*
- ☐ Loss of spouse's coverage*
- ☐ No longer dependent child*
- ☐ Death of dependent*
- ☐ Name Change
- ☐ Other

*Date of event above: _____

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Add	Remove	Last Name	First Name	MI	Spouse or Dependent	Gender M/F	Birthdate (MM/DD/YY)
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer servic e personnel) a ll information necessary to determ ine (1) eligibi lity for cover age and (2) covered benefits. This authorization is made for each individual to be enrolled or aff ected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting informat ion in connection w ith enrollment, coverage reinstatement, or requests t o change benefits. The a uthorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4 CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I authorize payroll deductions.

Signature: _____ Date: _____ DAR-ENR-12

Note: For new hires, the effective date will be first of the month following the signature date provided on this form.