Dental Enrollment Form

Part 1: Employee Information:

Social Security #:		Department:	
Last Name:		Home Address:	
First Name: M.I.		City: State: Zip:	
Date of Hire:		Date of Birth:	Male____Female____
Effective Date:		Marital Status:	

Part 2: Plan Selection: The "cost" amounts listed below are deducted each pay period.

Delta Dental		
Plan	**Tier**	**Cost**
Delta Premier 50/50 (Base Plan) 3238-0005, 0007	☐ Single	Ch. 78
Delta Preferred 80/20 3238-6003, 6004	☐ Single ☐ Family	$4.10 $31.78
Delta Premier 80/20 3238-0006,0008	☐ Single ☐ Family	$7.47 $43.25
Delta Enhanced Premier 3238-0012, 0013	☐ Single ☐ Family	$11.19 $55.95

Delta Dental (Officer Plans)		
Plan	**Tier**	**Cost**
County Police Officer 1296-0002	☐ Composite	$14.82
Correction Officer 1296-0004	☐ Composite	$19.35
Sheriff Officer 1296-0005	☐ Composite	$23.79

Eastern Dental (DSO)		
Plan	**Tier**	**Cost**
GJ2102, GJ2081	☐ Single ☐ Employee + 1 ☐ Employee + 2 or more	$3.57 $13.97 $29.11
Provide your dental center location and site ID number selection from the list of participating Dental Centers provided by Healthplex/Eastern Dental. Dental Center: _____ Site ID Number: _____		

Flagship DeltaCare		
Plan	**Tier**	**Cost**
3238-9001, 9002	☐ Single ☐ Employee + 1 ☐ Employee + 2 or more	$5.62 $17.61 $33.65
Provide your choice of dentist/dental center and location code number from the list Flagship DeltaCare participating providers. Dentist/Dental Center: _____ Location Code: _____		

Part: 3 Dependent Information:

Relation	Change Type	Dependent Name (Last Name, First Name MI)	Gender	Date of Birth	Social Security #
Spouse	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	

Part: 4 Status Change:

Type of Event: ☐ Marriage ☐ Birth ☐ Divorce ☐ Open Enrollment ☐ Other: _____

Date of Event: _____

_____ EMPLOYEE SIGNATURE

_____ DATE

Updated: November 2023