

# Enrollment/ Change Form



Delta Dental of Connecticut, Inc.  
P.O. Box 16354  
Little Rock, AR 72231  
Email: [eliginquiry@deltadentalnj.com](mailto:eliginquiry@deltadentalnj.com)

Please check the applicable box or boxes.

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- |                                               |                                                   |
|-----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> New enrollment       | <input type="checkbox"/> Address change           |
| <input type="checkbox"/> Change of dependents | <input type="checkbox"/> Coverage change          |
| <input type="checkbox"/> Termination          | <input type="checkbox"/> Name change              |
| <input type="checkbox"/> Decline Coverage     | <input type="checkbox"/> Continuation of Coverage |

Subgroup# \_\_\_\_\_ Plan Name  
DeltaVision®

**Vision:** Underwritten by Delta Dental of Connecticut, Inc. and administered by Vision Service Plan Insurance Company ("VSP")

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender
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Alternate Identification Number (if applicable)	Address (Is this a change of address?)	Street	City	State	Zip Code
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:			

Group Number	Sublocation	Group Name
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<b>Change of Coverage</b>		<b>Continuation of Coverage</b>	
New Coverage:	Former Coverage:	Coverage For	<input type="checkbox"/> Employee <input type="checkbox"/> Dependents
		Length of Continuation	<input type="checkbox"/> 18 Months <input type="checkbox"/> 36 Months

<b>Name Change</b>	
From:	To:

<b>Dependent Change</b> Please check one of the boxes:	Date of Loss of Coverage	Date of Qualifying Event
<input type="checkbox"/> Add dependent(s) listed below <input type="checkbox"/> Delete dependent(s) listed below		

Do you or your dependents have other vision coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete the following:</i>	Carrier Name and Address:
	Group Number:

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse/Civil Union / Domestic Partner (if coverage applies)			<input type="checkbox"/> M <input type="checkbox"/> F		
Children			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		

Date of Hire:	Effective Date:	Primary Enrollee Signature:	Date
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<b>Employer Verification - To Be Completed by Employer</b> The requested activity is believed eligible and is approved	Employer Signature	Title	Date
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Any person who includes any false or misleading information on an application for vision benefits is subject to criminal and civil penalties.  
This contract does not include coverage of pediatric vision services that meet requirements of the federal Patient Protection and Affordable Care Act.