Enrollment/Eligibility Update

DELTA DENTAL®

PLAN TYPE:
(AS ESTABLISHED BETWEEN EMPLOYER AND DELTA DENTAL)

- ☐ DELTA DENTAL PPO
- ☐ DELTA DENTAL PPO - PLUS PREMIER
- ☐ DELTA DENTAL PPO - PLUS PREMIER "ELITE"
- ■ DELTA DENTAL PREMIER
- ☐ DELTA DENTAL PREMIER - CHOICE
- ☐ DELTA DENTAL PPO - CHOICE
- ☐ DELTA DENTAL PPO - CHOICE ADVANTAGE
- ☐ DELTA DENTAL PPO - POINT OF SERVICE

www.DeltaDentalOK.org

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS, EXPLANATION OF CODES AND PRIVACY POLICY STATEMENT.

Employer: Cummins Construction Company, Inc.

GROUP#/SUBGROUP# 0 0 0 2 1 1 5 — 0 0 0 1

LOCATION CODE

Subscriber Information: *(please complete in ink for enrollment/eligibility updates)*

SUBSCRIBER NAME (LAST)	(FIRST)	(M.I.)	SUFFIX	SEX	MARITAL STATUS
				☐ M ☐ F	☐ M ☐ S

SUBSCRIBER SOCIAL SECURITY NUMBER	BIRTH DATE	FULL-TIME HIRE DATE	COVERAGE EFFECTIVE DATE
___ — ___ — ____	– –	– –	– –

STATUS
☐ Active ☐ COBRA
☐ Retiree ☐ Surviving Dep.
☐ Other: _____

ADDRESS

CITY	STATE	ZIP	CHECK HERE IF THIS IS A NEW ADDRESS
			☐

E-MAIL: _____

Enrollment/Eligibility Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: __ __ - __ __ - __ __ __ __

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:
☐ NEW ENROLLMENT ☐ REINSTATEMENT ☐ OPEN ENROLLMENT
☐ COBRA ELECTION ☐ TERMINATION OF BENEFITS ☐ DECLINE
☐ TERMINATION OF EMPLOYMENT AS OF _____ - _____ - _____

☐ CHANGE IN CURRENT ENROLLMENT STATUS FOR: ☐ SUBSCRIBER ☐ DEPENDENTS

REASON FOR CHANGE:
☐ DIVORCE ☐ MARRIAGE ☐ NAME CHANGE ☐ LEGAL GUARDIANSHIP
☐ ADOPTION ☐ OTHER _____

GROUP TRANSFER-GROUP#/SUBGROUP# ___ ___ ___ ___ ___ ___ ___ — ___ ___ ___ ___

TO: GROUP#/SUBGROUP# ___ ___ ___ ___ ___ ___ ___ — ___ ___ ___ ___

Dependent Enrollment/Eligibility Update Information: *(please complete for spouse and/or dependent children for enrollment/eligibility update)*

SPOUSE NAME (LAST)	(FIRST)	(M.I.)	SUFFIX	SEX
				☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER	BIRTH DATE
___ — ___ — ____	– –

DEPENDENT CHILD NAME (LAST)	(FIRST)	(M.I.)	SUFFIX	SEX
				☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER	BIRTH DATE	
___ — ___ — ____	– –	☐ DISABLED*

DEPENDENT CHILD NAME (LAST)	(FIRST)	(M.I.)	SUFFIX	SEX
				☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER	BIRTH DATE	
___ — ___ — ____	– –	☐ DISABLED*

DEPENDENT CHILD NAME (LAST)	(FIRST)	(M.I.)	SUFFIX	SEX
				☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER	BIRTH DATE	
___ — ___ — ____	– –	☐ DISABLED*

DEPENDENT CHILD NAME (LAST)	(FIRST)	(M.I.)	SUFFIX	SEX
				☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER	BIRTH DATE	
___ — ___ — ____	– –	☐ DISABLED*

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma and acknowledge I have read the privacy policy detailed on the back of this form.

Subscriber's Signature: _____ Date: _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or updating/changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the primary subscriber. Please print clearly in ink.

Full-Time Hire Date:	The date you were hired with your employer.
Coverage Effective Date:	The date Delta Dental coverage takes effect for you (and/or your dependents, if enrolled).

Status Definitions (Please select only one status)

Active	You are an eligible subscriber.
Retiree	You are retired and your employer continues to provide you with dental benefits.
COBRA	You are no longer an active subscriber but you have continued coverage under COBRA. Please check with your human resources or personnel department for information regarding COBRA.
Surviving Dep.	The surviving spouse or child of a deceased subscriber to whom the employer continues to provide benefits other than under provisions of COBRA.

Enrollment/Eligibility Update Information - This section should only be completed if your are: (1) enrolling yourself or a family member for the first time or (2) if your benefits were terminated and are not being reinstated or (3) if you are making changes to your current enrollment information.

New Enrollment:	Check for first time enrollment for yourself or your eligible dependents.
Reinstatement:	Check for reinstatement coverage for yourself or your eligible dependents.
Termination of Benefits:	Check only if you are terminating Delta Dental coverage for yourself or a family member.
Group Transfers:	Must be completed when you are transferring from one subgroup to another. (All dependents will transfer)

Dependent Enrollment/Eligibility Update Information - This section should be completed when: (1) enrolling dependents or (2) if you are submitting updates/changes to Delta Dental enrollment. (Please include both first and last names of any individuals for whom you are enrolling or submitting an update or change).

* Disabled:	Your permanently disabled dependent child. (Requires submission of medical statement)

Delta Dental of Oklahoma
Privacy Policy

All companies part of the Delta Dental of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality. For this reason and in compliance with the Gramm-Leach-Bliley Act of 1999, Delta Dental has developed a Privacy Policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental has which may contain your confidential information. Financial companies are able to choose how they share your personal information, however Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

Information We Collect - We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, check, credit or debit card payments, insurance claims, and our website. We also collect your personal information from other companies. The types of personal information we collect and share depend on the product or service you have with us. This information can include your name, address, social security number, date of birth, transaction and claim history, medical information, and checking account information.

Utilization Of Information - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business in order to provide our Customers with services and products. These functions include processing your requests, claims and transactions, maintaining your account(s), providing information about new products, responding to court orders and legal investigations, reporting to credit bureaus, and to comply with Federal and State Laws. The information Delta Dental uses to provide a service cannot be restricted by our Customers. However, Delta Dental is able to limit this information on your behalf under HIPAA.

Federal law gives consumers the right to limit information sharing in relation to affiliates' everyday business purposes, information about your creditworthiness, affiliates using your information to market to you, and non-affiliates using your information to market to you. In addition, state laws and other individual companies may give you additional rights to limit sharing.

Delta Dental does not have any affiliates, nor do we share information with non-affiliates for marketing purposes. When you are no longer our Customer, we will continue to share your information as described in this notice.

Our Security - To protect your personal information from unauthorized access and use, we maintain physical, electronic, and procedural safeguards that comply with Federal Law, including computer safeguards and secured files and buildings. We consider nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process.

While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers. Therefore, our Customer's confidential information is protected.

If the group plan is terminated or you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at 800-522-0188 (Toll Free) or 405-607-2100 (OKC Metro).

Under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.