



Delta Dental of South Dakota
720 N Euclid Ave, Pierre, SD 57501
800-627-3961 Fax 605-224-0909
eligibility@deltadentalsd.com

Enrollment/Change Form

Effective date: _____

Hire date: _____

Dental Group number: _____ Vision Group number: _____

Group name: _____

Employee name: _____ SSN: _____

Mailing address: _____ Birth date: _____

City/State/Zip: _____ Gender: ___M ___F

Cell phone* _____ Email:* _____

Marital status (we do not recognize common law marriage): Single ___ Married ___ ☐ Dental ☐ Vision

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐ Add Spouse					☐ Dental
☐ Drop					☐ Vision

Cell phone* _____ Email* _____

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐ Add Child					☐ Dental
☐ Drop					☐ Vision

Cell phone* _____ Email* _____

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐ Add Child					☐ Dental
☐ Drop					☐ Vision

Cell phone* _____ Email* _____

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐ Add Child					☐ Dental
☐ Drop					☐ Vision

Cell phone* _____ Email* _____

Change in coverage

Marriage date: _____ Divorce date: _____

Other (explain): _____ Date of change: _____

Signature: _____ Date: _____

DeltaVision is offered to you in partnership with EyeMed and underwritten by Wellness 605, Inc., a wholly owned company of Delta Dental of South Dakota. DeltaVision and Delta Dental are registered marks of Delta Dental Plans Association.

Delta Dental (DDSD) Coverage I accept the dental insurance provided by my employer and allow payroll deductions toward the cost of insurance (if any). I understand that I need to remain enrolled and cannot make a change in coverage until the next open enrollment period.

Wellness 605, Inc. Coverage I accept the vision insurance provided by my employer and allow payroll deductions toward the cost of insurance (if any). I understand that I need to remain enrolled and cannot make a change in coverage until the next open enrollment period.

Waiver of Coverage If I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any future enrollment form will be subject to the terms and conditions of my employer's Policy. I also understand that DDSD and Wellness 605, Inc. reserve the right to reject the enrollment form.

* I agree to let DDSD and Wellness 605, Inc. use this information for surveys for people over 18. Email and text messages may not be secure.