



## VOLUNTARY GROUP DENTAL PLAN

Please **PRINT** or **TYPE**

### ENROLLMENT AND STATUS CHANGE FORM

**Be sure form is completed in full for accurate enrollment.**

Rocky Mountain Health Plans  
2775 Crossroads Blvd.  
PO Box 10600  
Grand Junction, CO 81502-5600

### ENROLLMENT FOR FRONT RANGE ONLY

<b>ENROLLEE INFORMATION</b> (one form must be completed per person)				
1. Group Name: Rocky Mountain Health Plans		2. Group Number: 7159		3. Effective Date:
4. Social Security No.: / /	5. Date Of Birth: / /	6. Last Name (Subscriber):	7. First Name:	8. Phone:
9. Home Address:		10. City:	11. State:	12. Zip Code:
<b>PLAN SELECTION</b>				
13. <b>Plan:</b> <input type="checkbox"/> <b>Yes</b> , I choose to elect coverage in the <b>Delta Dental PPO MAC</b> .				
<b>REASON FOR SUBMISSION (CHECK ONE)</b>				
14. <b>Enrollment:</b>  <input type="checkbox"/> New Enrollment  <input type="checkbox"/> Cancel Coverage		15. <b>Change Type:</b>  <input type="checkbox"/> Change Name From _____ To _____ <input type="checkbox"/> Change Address From _____ To _____		
_____ <b>16. Signature of Subscriber</b>		_____ <b>Date</b>		
It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance, 303-894-7499 or 800-930-3745.				
<b>FOR DDPC USE ONLY</b>				
Group # 7159	Effective Date	Billing Code	Account Executive: BP	