



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 WESTERN SLOPE ONLY

ENROLLEE INFORMATION (one form must be completed per person)			
1. Group Name: Rocky Mountain Health Plans		2. Group Number: 7515	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:			
PLAN SELECTION			
13. Plan: <input type="checkbox"/> Yes, I choose to elect coverage in the Delta Dental Premier.			
REASON FOR SUBMISSION (CHECK ONE)			
14. Enrollment:		15. Change Type:	
<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Change Name	
<input type="checkbox"/> Cancel Coverage		<input type="checkbox"/> Change Address	
		From _____	
		To _____	
_____		_____	
16. Signature of Subscriber		Date	
It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental 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.			
FOR DDPC USE ONLY			
Group # 7515	Effective Date	Billing Code	Account Executive: BP