**Enrollment/Change Form**

Please check the applicable box or boxes.

- [ ] New enrollment
- [ ] Address change
- [ ] COBRA
- [ ] Change of dependents
- [ ] Coverage change
- [ ] Name change

Primary Enrollee Social Security Number: [ ]

Last Name: [ ]
First Name: [ ]

MI Date of Birth: [ ]
Gender: [ ] Male [ ] Female

Alternate Identification Number (If applicable): [ ]
Address (Is this a change of address? [ ] Yes [ ] No): [ ]
Street: [ ]
City: [ ]
State: [ ]
Zip Code: [ ]

Group Number: 1261
Sublocation: [ ]
Group Name: STATE OF DELAWARE

Change of Coverage:
New Coverage: [ ]
Former Coverage: [ ]

Name Change:
From: [ ]
To: [ ]

Dependent Change:
Please check one of the boxes:
- [ ] Add dependent(s) listed below
- [ ] Delete dependent(s) listed below

Do you or your dependents have other dental coverage?
- [ ] Yes [ ] No [ ] If yes, please complete the following:
  Carrier Name and Address: [ ]
  Group Number: [ ]

<table>
<thead>
<tr>
<th>Last Name (If different)</th>
<th>First Name</th>
<th>MI</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>[ ]</td>
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<tr>
<td>Children</td>
<td>[ ]</td>
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</tr>
</tbody>
</table>

Date of Hire: [ ]
Effective Date: [ ]
Primary Enrollee Signature: [ ]

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

EC/11/05