



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

VOLUNTARY GROUP DENTAL PLAN

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

ENROLLMENT AND STATUS CHANGE FORM
 Be sure form is completed in full for
 accurate enrollment

ENROLLMENT FOR FRONT RANGE ONLY

ENROLLEE INFORMATION (one form must be completed per person)					
1. Group Name: Rocky Mountain Health Plans		2. Group Number: 7159	3. Effective Date (mm/dd/yyyy)		
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 PPO MAC .					
REASON FOR SUBMISSION (CHECK ONE)					
14. Enrollment: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Cancel Coverage		15. Change Type: <input type="checkbox"/> Change Name <input type="checkbox"/> Change Address From _____ From _____ To _____ 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 provide 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 DDCO USE ONLY					
Group # 7159	Effective Date	Billing Code	Account Executive: Lorri Kohle		