



Delta Dental of Nebraska
Disabled Dependent Application
www.deltadentalne.org

PARTS A, B, and C TO BE COMPLETED BY EMPLOYEE (Please Print)

PART A – EMPLOYEE INFORMATION

Employee's Name:		Last	First	Middle Initial	Social Security Number / /	
Employee's Address:	Address		Home Phone Number ()		Work Phone Number ()	
	City		State		Zip Code	
Group Name:				Group Number:		

PART B – DEPENDENT CHILD INFORMATION

Dependent Child's First Name, Middle Initial, Last Name:			Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (Month-Day-Year) / /	
Relationship to Employee:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			Date Disability Occurred: (Month-Day-Year) / /	
Does Dependent Child Permanently Reside In Your Household? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," provide an explanation:						
Is Child a Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Child Dependent Upon You For Support? <input type="checkbox"/> Yes <input type="checkbox"/> No		What Percentage of Support Do You Provide?		
Was Child Listed as a Dependent On Your Last Federal Income Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No			Has Child Ever Been Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Child Currently Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Child Has Been or Is Currently Employed List Employer Name and Address				Employment Start Date		Employment End Date
				/ /		/ /
				/ /		/ /
Name of Attending Physician Who Is Certifying Disability:						
Physician's Address:	Address			Office Phone Number ()		
	City			State		Zip Code

PART C – EMPLOYEE SIGNATURE

I am requesting continued coverage for this dependent and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the account agreement and Certificate of Coverage.

I authorize all health and dental care providers, third party payers, my employer, and state or federal agencies to exchange all demographic and dental information with Delta Dental of Nebraska or its designees necessary for claims processing, plan administration, and benefit determination.

I give this consent for myself and any eligible family members listed on this application for whom I am authorized to do so. I understand that failure to sign this authorization may be basis for enrollment or benefit denial. I understand I am entitled to receive a copy of this authorization. I further understand that this authorization will remain in effect until coverage under this plan ends or I give written notice to Delta Dental that I want to revoke this authorization. I understand that revocation of this authorization may be a basis for denying benefits.

Employee Signature _____ **Date** _____

Note: Return completed forms to your employer for authorization and submission to Delta Dental of Nebraska.

PART D – ATTENDING PHYSICIAN INFORMATION -- TO BE COMPLETED BY ATTENDING PHYSICIAN

Is Child Now Incapable Of Self-Support Because Of A Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disability Has Existed Continuously Prior To Age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		Expected Length of Disability (Prognosis - Estimate Months Or Years Disability Will Continue):	
Reason or Nature Of Disability (Please Give As Much Detail As Practicable):					
Physician Signature _____				Date _____	

PART E – GROUP INFORMATION -- TO BE COMPLETED BY EMPLOYER

Send Form To: Delta Dental of Nebraska ♦ Attention: Enrollment Department ♦ PO Box 330 ♦ Minneapolis MN 55440-0330

Group Representative's Signature:	Date:	Phone Number: ()
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