DELTACARE®

ENROLLMENT/CHANGE FORM

These forms must be received at HealthSmart before the 15th of the month prior to requested effective date.

Future new hire and qualifying event forms should be sent to:
HealthSmart Benefit Solutions, Inc.
Phone: (800) 786-6525
FAX: (303) 804-9490
Email: PBDenver@healthsmart.com

FOR EMPLOYER USE ONLY
Group No. ----------
Contract Type ----------
Effective Date ----------

Check One

- ☐ New Enrollment
- ☐ Name Change
- ☐ Facility Change*
- ☐ COBRA
- ☐ New Social Security Number/ Employee ID Number
- ☐ Address Change
- ☐ Add Dependent
- ☐ Remove Dependent

Indicate effective date of change:
*(Does not pertain to facility change)

(Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- ☐ Termination
- ☐ Divorce
- ☐ Widowed
- ☐ Surviving Dependent
- ☐ Overage Dependent

Indicate qualifying date:

(Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last) (First) (M.I.)

Mailing Address: (Street Address)

(City) (State) (Zip Code)

Date of Birth (Month) (Day) (Year)

☐ Male ☐ Female

Home Phone #: ( ) –

Name of Employer/Group:

Location:

Soc. Security #: – –

Employee Identification #:

Contract Facility Name:

Contract Facility #:

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.) Note: You may choose up to three separate offices for yourself and all dependent enrollees.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Gender (Check One) M F	Date of Birth (Month) (Day) (Year)	Contract Facility Name	Contract Facility #:

*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:
Spouse - SP Domestic Partner - DP Child - CH Child of DP - CD Other Adult - OA Other Child - OC

NOTE: If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event.

Signature of Primary Enrollee _____ Date: _____