Appendix 2-D

DELTA DENTAL®

Delta Dental Plan of Kansas

ELIGIBILITY TRANSMITTAL

P.O. Box 49198
Wichita, KS 67201-9198
Phone (316) 264-1099
Fax (3160 264-6867

Please return this form, appropriate Enrollment/Change form(s), and the Statement of Account with your payment

Group Number: _____

Group Name: _____ Date: _____

Action Code*	Employee Soc. Sec. #	Employee Name		Employee Birthdate	Effective Date	Coverage Type	Total
		Last	First				
						TOTAL	

*Action Codes:

1 = Addition
2 = Termination
3 = Effective Date Change
4 = Coverage Type Change

Note: Appropriate Enrollment/Change form must be attached for all Additions and Coverage Type changes.