



Garland-Hill Agency, Inc.

Dear Union Member:

As a Member of AFGE, you have the opportunity to participate in Delta Dental plans that are serviced by the Garland-Hill Agency, Inc. In order to provide the best possible service, Professional Benefit Administrators will be responsible for remitting premium deductions to Delta Dental on your behalf. Please review the necessary enrollment forms for detailed information.

IMPORTANT CONTACT INFORMATION

Benefits, Claims, and Eligibility:

Delta Dental of Illinois

Customer Service: 800-323-1743 | Website: www.deltadentalil.com

Delta Dental of Illinois Claims, PO Box 5402, Lisle, IL 60532

Delta Dental Inquiries: CSI@deltadentalil.com

Enrollment or Plan Adjustments:

Garland-Hill Agency

30700 Telegraph Rd, Suite 2620, Bingham Farms, MI 48025

Phone: (866) 582-1777 Fax: (313) 965-1696

Dental Enrollment Questions: Dental@GarlandHill.com

Premium Payments:

Professional Benefit Administrators

1000 Hurricane Shoals Rd NE, Suite C-370, Lawrenceville, GA 30043

Phone: (800) 578-2082 Fax: (770) 963-6126

MULTIPLE CONVENIENT PAYMENT OPTIONS

PLEASE COMPLETE ALL FORMS FOR YOUR PAYMENT METHOD

Bi-Weekly

Federal Allotment*

- Eligibility Enrollment/Update Form
- Payroll Deduction Authorization Form
- 1199A Form – Direct Deposit Form

****You must include a check for three (3) Weekly Allotments**

Monthly

Bank Draft

- Eligibility Enrollment/Update Form
- Bank Draft Authorization Form

****You must include a check for one (1) Months Premium**

Direct Bill

Quarterly, Semi-Annual, or Annual Bill

- Eligibility Enrollment/Update Form

Bank Draft

- Check for Premium Method

Credit Card

- Credit Card Authorization Form

*If your Allotment does not start in a timely manner, you will be responsible for sending the missed premium directly to Professional Benefits Administrators at the address above. Delta Dental requires that one month's premium is paid prior to coverage becoming effective. After a total of three (3) biweekly Allotment amounts are received by Delta Dental by the 28th of the month, the coverage will be effective on the first day of the following month.

Office 313.965.1777 • Toll Free 866.582.1777 • Fax 313.965.1696
www.GarlandHill.com



Delta Dental of Illinois Enrollment/Change of Status Form for Group/Employer Dental Policy

**ATTENTION: Eligibility Department | P.O. Box 3384 | Lisle, Illinois 60532
PHONE: (800) 323-1743**

Please type or print in black ink and complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

MEMBER

Last Name		First Name		Middle Initial	Date of Birth _/_/____
Gender	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partnership			Social Security Number or Alternate ID Number	

Member Status

Salaried Hourly Non-Union Other _____

Mailing Address		City	State	ZIP
Phone Number ()		Email Address		
Name of Group/Employer		Group/Employer Number	Sublocation Number (if applicable)	
Requested Effective Date of Coverage _/_/____		Date of Hire/Rehire _/_/____		

I consent to receive Explanation of Benefits (EOBs) from Delta Dental of Illinois by Email. Yes No

I consent to receive policy and legally required communications from Delta Dental of Illinois by Email. Yes No

MEMBER/DEPENDENT ADDITIONS/CHANGES

Please check two of the options below.

Yes, I want to enroll in this group/employer dental benefit plan offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

Delta Dental PPOSM/Delta Dental Premier[®]

DeltaCare (please complete the section below)

Dentist Name _____ Address _____ Facility Code _____

No, I do not want to enroll in this group/employer dental benefit plan offered by Delta Dental of Illinois.

Yes, I want to enroll in this group/employer DeltaVision^{®*} Coverage.

No, I do not want to enroll in this group/employer DeltaVision Coverage.

CONTINUED ON NEXT PAGE

REASON(S) FOR SUBMITTING THIS FORM

Initial or Open Enrollment

COBRA

End Date ___/___/___

Retiree

Reinstatement due to:

Rehire Loss of Other Coverage Other _____

Add Dependent due to:

Birth Adoption/Placement for Adoption Marriage Domestic Partnership

Civil Union Legal Guardianship Loss of Other Coverage

Dependent Child with Disability Military Dependent Court Order Other _____

Date of Qualifying Event ___/___/___

Drop Dependent due to:

Age Death Divorce Other Coverage Elsewhere

Date of Qualifying Event ___/___/___

Name Change

Former Name _____ New Name _____

Address Change _____

DeltaCare Dentist Change

Termination of Employment

Date ___/___/___

ENROLLMENT SELECTION

Select one for dental:

Member Only

Member Plus One Dependent

Family

Member Plus Child(ren)

Are you and/or your dependent(s) covered by any other dental benefit program? Yes No

If "Yes," list the name of the carrier: _____

Select one for DeltaVision:

Member Only

Member Plus One Dependent

Family

Member Plus Child(ren)

CONTINUED ON NEXT PAGE

DEPENDENTS

Indicate the names of all dependents to be insured or terminated under the Group/Employer Policy.

Add	Delete	First Name	Last Name (If different from Member)	Date of Birth MM/DD/YYYY	Relationship to Member	Dependent Status	Gender
<input type="checkbox"/>	<input type="checkbox"/>			__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	
<input type="checkbox"/>	<input type="checkbox"/>			__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	
<input type="checkbox"/>	<input type="checkbox"/>			__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	
<input type="checkbox"/>	<input type="checkbox"/>			__/__/__		<input type="checkbox"/> Military <input type="checkbox"/> Disabled	

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits.

Signature of Member	Date __/__/__
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**DeltaVision is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.*