DELTA DENTAL

FPPA
Fire & Police Pension Association

Enrollment & Premium Authorization Form

Group Name: Fire and Police Pension Association Effective date of Coverage: _____

Plan design (please select one option below)

☐ **Option Low (group #8818)** ☐ **Option Medium (group #8819)** ☐ **Option High (group #8820)**

SUBSCRIBER INFORMATION

Subscriber Name:_____ Sex ☐ Male ☐ Female
(Last, First, M.I.)

Subscriber SSN:_____ Birth date: _____
(mm-dd-yyyy)

Street Address: _____

City: _____ State: _____ Zip: _____

DEPENDENTS TO BE COVERED

Spouse Name:_____ Sex ☐ Male ☐ Female
(Last, First, M.I.)

Spouse SSN: _____ Birth date: _____
(mm-dd-yyyy)

Dependent Name:_____ Sex ☐ Male ☐ Female
(Last, First, M.I.)

Dependent SSN: _____ Birth date: _____
(mm-dd-yyyy)

Dependent Name:_____ Sex ☐ Male ☐ Female
(Last, First, M.I.)

Dependent SSN: _____ Birth date: _____
(mm-dd-yyyy)

Dependent Name:_____ Sex ☐ Male ☐ Female
(Last, First, M.I.)

Dependent SSN: _____ Birth date: _____
(mm-dd-yyyy)

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 provides 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.

Signature of Subscriber: _____ Date: _____