DELTA DENTAL®

Delta Dental of Minnesota

Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:	Last		First			Middle Initial		**Social Security Number** / /
Gender:	Male ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address					Home Phone Number ( )		Work Phone Number ( )
	City			State		Zip Code		

PART B – ENROLLMENT INFORMATION

Select Coverage Type – Who is Being Enrolled – Check One Box Only *If waiving coverage for employee and/or eligible family members, complete Part B & D.		**Plan Design Type – Check One Box Only**
☐ Employee only*	☐ Employee + 1	☐ Option 1
☐ Family	☐ No Coverage*	☐ Option 2

PART C – DEPENDENT INFORMATION

Relationship To Employee	**First Name, Middle Initial, Last Name** (Include Last Name Only if Different From Employee's)	**Gender**		**Date of Birth** Month/Day/Year	**Unmarried?**	
Spouse		M	F	/ /		
Dependent Child		M	F	/ /	Y	N
Dependent Child		M	F	/ /	Y	N
Dependent Child		M	F	/ /	Y	N
Dependent Child		M	F	/ /	Y	N

PART D – OTHER INSURANCE COVERAGE

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: _____ Policy/Identification No.:_____

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Employee Signature: **Date:**

PART E – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: **Date:**

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Rehire** Date Lay Off Began: _____/_____/_____
Date Rehired: _____/_____/_____

☐ **Return from Leave of Absence**
Date Leave Began: _____/_____/_____
Date Returned to Work: _____/_____/_____

☐ **Existing Delta Dental Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Employee Change Part Time to Full Time**
Date of Status Change: _____/_____/_____
Effective Date: _____/_____/_____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine
Effective Date: _____/_____/_____
Hire Date: _____/_____/_____

☐ **Open Enrollment**
Effective Date:
_____/_____/_____

☐ **Previously Waived Coverage or Loss of Coverage**
Qualifying Event Reason: _____
Hire Date: _____/_____/_____
Event Date: _____/_____/_____
Effective Date: _____/_____/_____

Group Name: **Group & Subgroup Numbers:** ----

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

Send Original Copy to Delta Dental Retain Copy For Your Records

Employer Instructions

- Review Parts A, B, C, D, E to assure the employee provided complete, accurate and legible information.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).

Complete Part F – Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group –** New customer to Delta Dental and submitting initial employee enrollment. Note: For a New Group enrolling a Direct Billed COBRA participant, check *Other* category. Provide reason and original date of qualifying event and correct COBRA subgroup. If information is not provided, participant will not be enrolled and billed properly.
- **Open Enrollment –** Employee is enrolling during group's open enrollment period.
- **New Hire –** Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Other –** Use if enrollment situation is not included in another category. Provide a specific reason and event date.
- **Previously Waived Coverage –** If an employee waives coverage, they can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage.
- **Employee Status Change –** Employee's employment status changed and employee is now eligible for dental benefits.
- **Group Name –** Provide group name as listed in your contract.
- **Group and Subgroup Number –** Provide applicable numbers for individual employee.
- **Group Representative –** Sign, date, and provide your phone number.

Send Completed Forms To:

Delta Dental of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis MN 55440-0330
Fax: 651-406-5935 or 800-821-5946