

Client Name		Client/Subclient #		-	
PART A - PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):					
Type of Update: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Change/Correction to Information <input type="checkbox"/> Termination <input type="checkbox"/>					
Transfer From: Client/Subclient #		Transfer To: Client/Subclient #		Change is for: <input type="checkbox"/> Subscriber <input type="checkbox"/> Dependent	
-		-		<input type="checkbox"/> Spouse/Domestic Partner	
PART B - FOR MILLENNIUM CHOICESM PRODUCT ONLY			Select a Plan Option: <input type="checkbox"/> Plan Option I - Delta Dental PPO		
			<input type="checkbox"/> Plan Option II - Delta Dental Premier		
PART C - SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):					
Subscriber Name (Last)		(First)		(Middle initial)	Gender
Social Security Number	Birth Date (Month-Day-Year)	Effective Date (M/D/Y)		Hire Date (M/D/Y)	
Street Address				<input type="checkbox"/> Check here if this is a new address	
City	State	Zip Code		Status* <input type="checkbox"/> Active <input type="checkbox"/> COBRA	
				<input type="checkbox"/> Retiree <input type="checkbox"/> Surviving	
PART D - DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):					
Relationship to Employee	Last Name, First Name, M.I. (Include Last Name only if different from Subscriber's)	Gender	Date of Birth (M/D/Y)	Social Security Number-requested but not required**	Status*
Spouse/Domestic Partner					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving
Dependent Child					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
Dependent Child					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
Dependent Child					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
Dependent Child					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
*see reverse side for instructions and explanation of codes					
**Social security number only requested for dependents with same date of birth					
PART E - SUBSCRIBER AND CLIENT SIGNATURE - Sign and date form as verification of your enrollment					
<input type="checkbox"/> I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.					
<input type="checkbox"/> 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.					
Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
_____			_____		
Name of Carrier			Policy/Identification Number		
Employee Signature: _____			Date: _____		
Client Representative Signature _____			Date: _____		
<i>For Employer Use Only:</i>					
Qualifying Event (see next page for list of qualifying events) _____				Date of Qualifying Event: _____	

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your employer continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Plan Enrollment/Update Information - This section should only be completed if you are: 1) Enrolling yourself or a family member for the first time, or 2) if your benefits were terminated and are not being reinstated or, 3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Transfers: When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

Enrollment/Corrections To Information - This section should be completed when: 1) enrolling dependents or, 2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse or domestic partner

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's contract with Delta Dental.

Full Time Student: An individual who is your dependent child according to the U.S. Internal Revenue Code. This Student could include your married or unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Qualifying Events (for Employer Use Only) -

A - Adoption	L - Loss of Coverage	T - Termination/Reduction of Work Hours
B - Birth	M - Marriage	V - Employee Total Disability
D - Divorce/Legal Separation	O - Open Enrollment	X - Employee Eligible for Medicare
E - Death	S - Dependent No Longer Eligible	



Email: eligibility@mydeltadental.com



Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota and its affiliates, (collectively referred to herein as “Delta Dental of Minnesota”) comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card

If you believe that Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Minnesota, Attn: Compliance Officer, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-448-3815 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-448-3815 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-448-3815 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-448-3815 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-448-3815 (TTY: 711)。 (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-448-3815 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-448-3815 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-448-3815 (መስማት ለተሳናቸው: 711). (Amharic)

ဟံသုဂ်ບတ်သး- နမ့်ကတိၤ ကညီ ကျိၣ်ဆယ်, နမၤန့ၢ် ကျိၣ်ဆတ်မၤစၢၤလၢ တလၢ်ဘျုးလၢ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-800-448-3815 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-448-3815 (TTY: 711). (German)

ملحوظة 711). رقم (1-800-448-3815 برقم اتصل. بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تتحدث كنت إذا: ملحوظة (Arabic) ه الصم والبكم:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-448-3815 (ATS : 711). (French)

주의 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-448-3815 (TTY: 711) 번으로 전화해 주십시오 (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-448-3815 (TTY: 711). (Tagalog)

بکه. بهر دهسته (Kurdish) تو بۆ بهخۆراپی، زمان یارمهتی خزمهتگوزاریهکانی، دهکههیت قهسه کوردی زمانی به نهگهر: ناگاداری پ به 1-800-448-3815 (TTY: 711)

بگیرید. شما برای رایگان بصورت زبانی تسهیلات، کنید می گفتگو فارسی زبان به اگر: توجه ف می باشد. یا 1-800-448-3815 (TTY: 711) تماس (Persian / Farsi)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-448-3815 (TY:711) まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-448-3815 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-448-3815 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistentsetjenester tilgjengelige for deg. Ring 1-800-448-3815 (TTY: 711). (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-448-3815 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षणः यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, निःशुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-800-448-3815 (TTY: 711) मा कल गर्नुहोस्। (Nepali)



**Minnesota Clerical Inc.
For Client # T06509
Dental Flex
Summary of Dental Plan Benefits**

Service Type	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays*	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, and fluoride	100%	80%	80%
Radiographs - X-rays	100%	80%	80%
Periodontal Maintenance - cleanings following periodontal therapy	100%	80%	80%
Basic Services			
Space Maintainers - appliances to prevent tooth movement	80%	50%	50%
Emergency Palliative Treatment - to temporarily relieve pain	80%	50%	50%
Sealants - to prevent decay of permanent teeth	80%	50%	50%
Minor Restorative Services - fillings	80%	50%	50%
Anesthesia Services - when medically necessary	80%	50%	50%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Endodontic Services - root canals	50%	50%	50%
Periodontic Services - to treat gum disease	50%	50%	50%
Oral Surgery Services - extractions and dental surgery	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Other Basic Services - misc. services	50%	50%	50%
Relines and Repairs - to bridges and dentures	50%	50%	50%
TMD Treatment - treatment of the disorder of the temporomandibular joint, including related films	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

Coverage Year - Your coverage year is January 1 through December 31

Benefit Waiting Period - There is a 6-month waiting period for certain services. Endodontic Services, Periodontic Services, Extractions, and TMD Treatment will not be covered until after a person is enrolled in the dental plan for 6 consecutive months. Crown Repair, Major Restorative Services, Other Basic Services, Relines and Repairs, and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months.

Missing Tooth Clause - Payment will not be made to replace a missing tooth lost before the start of coverage until the member has been eligible for 24 consecutive months.

Deductible - \$50 Deductible per person total per Coverage Year limited to a maximum Deductible of \$150 per family per Coverage Year. The Deductible does not apply to oral exams, prophylaxis, fluoride treatment, X-rays, and periodontal maintenance.

Annual Maximum - \$1,000 per person total per Coverage Year on all services.

RATES: DELTA DENTAL PLAN/

Effective: Jan 1, 2022 to Dec 31, 2022 monthly premium:

Single: \$30.20

Single and Spouse: \$60.40

Single and child(ren): \$75.24

Family: \$101.75

Visit www.deltadentalmn.org and click on "Dentist Search" to locate participating dentists near you.