DELTA DENTAL

# Delta Dental of Minnesota

## *Membership Enrollment Form*

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru G 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 | | | Day Phone Number | Evening 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 F. | **Complete If Your Employer Offers The Voluntary Orthodontic Program** |
|---|---|
| ☐ Employee only* ☐ Family<br>☐ Employee and Spouse ☐ No Coverage*<br>☐ Employee and Dependent Child(ren) | ☐ I Elect ☐ I Do Not Elect to Participate in the Voluntary Discount Orthodontic Program |

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 | **Full Time Student?** | | **Unmarried?** | |
|---|---|---|---|---|---|---|---|---|
| Spouse | | M | F | / / | | | | |
| Dependent Child | | M | F | / / | Y | N | Y | N |
| Dependent Child | | M | F | / / | Y | N | Y | N |
| Dependent Child | | M | F | / / | Y | N | Y | N |

| | |
|---|---|
| PART D – FOR MILLENNIUM CHOICE℠ GROUPS ONLY | **Select a Plan Option:** ☐ Plan Option I - Delta Dental PPO ☐ Plan Option II - Delta Dental Premier |
| PART E – FOR DeltaCare GROUPS ONLY Obtain Clinic Code from DeltaCare Provider Directory. | **Clinic Code:** _____ Please Note: Dental benefits are ONLY available when a clinic is chosen. |

PART F – OTHER INSURANCE COVERAGE – Complete if employee and/or eligible dependents are not being enrolled.

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No
Name of Carrier: _____ Policy/Identification Number: _____

☐ 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 G – 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 misleafpding, 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 H – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

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

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

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

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

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

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

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

# Employer Instructions

- Review Parts A, B, C, D, E, F and G to be sure all information is complete, accurate and legible.
- 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).
- Delta Dental of Minnesota generally completes enrollment requests within five business days of receipt.

**Complete Part H - 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. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies. Note: For a New Group enrolling a Direct Billed COBRA participant, write Direct Bill in the New Group section. If information is not provided, participant will not be enrolled and billed properly.
- **Existing Delta Dental Group** – Enrolling additional employees from an acquisition/merger who were not previously offered/enrolled in you Delta Dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **New Hire** – Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- **Open Enrollment** – An employee is enrolling during group's open enrollment period.
- **Rehire** – A former employee was rehired.
- **Return From Leave of Absence** – An employee is returning from leave of absence.
- **Employee Status Change** – The employee's employment status changed and the employee is now eligible for dental benefits.
- **Previously Waived Coverage or Loss of Coverage** – If an employee waives coverage, he/she 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. If an employee or dependent involuntarily losses coverage and are now eligible to enroll, complete this section.
- **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