

DENTAL ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY - IN BLUE OR BLACK INK ONLY

1. SUBSCRIBER INFORMATION - To be completed by Employee							
LAST NAME (SUBSCRIBER)		FIRST NAME		SOCIAL SECURITY / I.D. #		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (MM-DD-YYYY) - -
MAILING ADDRESS			CITY		STATE	ZIP	TELEPHONE NO. ()
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED / CIVIL UNION PARTNER <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER _____					E-MAIL		
2. GROUP INFORMATION							
GROUP NAME			STREET ADDRESS, CITY, STATE, ZIP				
GROUP NUMBER		SUBLOCATION NUMBER		DIVISION		MISC. INFO (i.e. STORE LOC)	
EFFECTIVE DATE (MM-DD-YYYY) - -		EMPLOYEE DATE OF HIRE (MM-DD-YYYY) - -		EMPLOYEE DATE OF REHIRE (MM-DD-YYYY) - -			
3. REASON FOR ENROLLMENT/CHANGE:							
EXACT DATE OF STATUS CHANGE _____ (MM-DD-YYYY)				MISCELLANEOUS CHANGE:			
ADD: <input type="checkbox"/> New enrollment <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> COBRA Due to: <input type="checkbox"/> Marriage/Civil union <input type="checkbox"/> Birth <input type="checkbox"/> Other: <input type="checkbox"/> Adoption <input type="checkbox"/> Employment change for spouse/civil union partner <input type="checkbox"/> Part-time to full-time employment status		DELETE: <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Employment change for spouse/civil union partner <input type="checkbox"/> Full-time to part-time employment status <input type="checkbox"/> Divorce/Termination of a civil union <input type="checkbox"/> Deceased <input type="checkbox"/> No longer dependent for IRS purposes <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____		<input type="checkbox"/> Name change - Previous name: _____ <input type="checkbox"/> Transfer from sublocation: _____ <input type="checkbox"/> Address change <input type="checkbox"/> Other: _____ COVERAGE LEVEL REQUESTED <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse/Civil union partner <input type="checkbox"/> Employee & Child <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family			
4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.							
Last Name (if Different)	First Name	M.I.	Relationship To Subscriber	Date Of Birth Mo Day Yr	Check if Dependent under age 26	*	E-Mail for Spouse and/or Dependents Over the Age of 14
*Check if dependent is incapacitated. Legal documentation may be required.							
5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)							
Will you, your spouse/civil union partner, or any dependent be covered under any other group plan while this policy is in effect?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Will this dental coverage replace another Northeast Delta Dental Plan?							<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to either question, complete the following:							
DENTAL INSURANCE COMPANY			POLICYHOLDER ID # / SOCIAL SECURITY #			EFFECTIVE DATE (MM-DD-YYYY) - -	
Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. By signing below I hereby accept coverage.							
This policy provides dental benefits only. Review your policy carefully.							
SIGNATURE (REQUIRED): _____				DATE: _____			