



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 <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status:		Single <input type="checkbox"/>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Legally Separated <input type="checkbox"/>	
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		Complete If Your Employer Offers The Voluntary Orthodontic Program	
* If waiving coverage for employee and/or eligible family members, complete Part F.			
<input type="checkbox"/> Employee only*	<input type="checkbox"/> Family	<input type="checkbox"/> I Elect <input type="checkbox"/> I Do Not Elect	
<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> No Coverage*	to Participate in the Voluntary Discount Orthodontic Program	
<input type="checkbox"/> Employee and Dependent Child(ren)			

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 CHOICESM GROUPS ONLY	Select a Plan Option: <input type="checkbox"/> Plan Option I - Delta Dental PPO <input type="checkbox"/> Plan Option II - Delta Dental Premier
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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.
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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 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 H – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> New Group Hire Date: _____ / _____ / _____ Prior Coverage Start Date (if applicable): _____ / _____ / _____ Coverage Effective Date: _____ / _____ / _____	<input type="checkbox"/> Rehire Date Lay Off Began: _____ / _____ / _____ Date Rehired: _____ / _____ / _____
<input type="checkbox"/> Existing Delta Dental Group Hire Date: _____ / _____ / _____ Prior Coverage Start Date (if applicable): _____ / _____ / _____ Coverage Effective Date: _____ / _____ / _____	<input type="checkbox"/> Return from Leave of Absence Date Leave Began: _____ / _____ / _____ Date Returned to Work: _____ / _____ / _____
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Effective Date Hire Date: _____ / _____ / _____ Effective Date: _____ / _____ / _____	<input type="checkbox"/> Employee Change Part Time to Full Time Date of Status Change: _____ / _____ / _____ Effective Date: _____ / _____ / _____
<input type="checkbox"/> Open Enrollment Effective Date: _____ / _____ / _____	<input type="checkbox"/> 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 your 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 loses 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