DELTA DENTAL®

# Delta Dental of Minnesota

## Membership Maintenance Form

### PART A - EMPLOYEE INFORMATION

| | | | |
|---|---|---|---|
| **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 |
| ☐ **Check If New Address** | City | State | Zip Code | |

### PART B – CHANGE REQUEST - Check all categories that apply and provide information requested by category.

☐ **Name Change**
Former Name:_____
New Name: _____

☐ **Terminate Employee and All Dependent Coverage**
Date of Termination: _____/_____/_____
Date Coverage Ends: _____/_____/_____

☐ **Change Employee Group/Subgroup** (Move individual to different subgroup, including to COBRA subgroup)
From:_____ To:_____
Effective Date of Change: _____/_____/_____

☐ **Millennium Choice Groups Change Plan Option at Open Enrollment**
☐Plan Option I - Delta Dental PPO ☐ Plan Option II - Delta Dental Premier

☐ **For DeltaCare Groups Change Clinic Code to:** _____
Obtain Clinic Code from DeltaCare Provider Directory

☐ **Enroll in Voluntary Discount Orthodontic Program**

☐ **Change Coverage Type, Add or Drop Dependent Due to Qualifying Event –** List Qualifying Event Code next to correct Coverage Type/Change Request Category. Complete Part C if Adding or Dropping Dependent(s). **Qualifying Event Code**: **A** – Adoption **B** – Birth **D** – Divorce/Legal Separation **E** – Death **L** – Loss of Coverage **M** – Marriage **O –** Open Enrollment **S –** Dependent No Longer Eligible

| Qualifying Event Code | Coverage Type / Change Request Category | Date of Qualifying Event | Effective Date of Change |
|---|---|---|---|
| | Employee Only | / / | / / |
| | Employee & Spouse | / / | / / |
| | Employee & Dependent Child(ren) | / / | / / |
| | Family | / / | / / |
| | Add or Drop Dependent - No Coverage Type Change | / / | / / |

### PART C – DEPENDENT INFORMATION – Adding or dropping dependents may require a Coverage Type change in Part B.

| Add | Drop | 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 |

### PART D – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment change.

☐ I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated below and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

**Employee Signature:** **Date:**

### PART E – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits Employer Note: May require subgroup change.

**Qualifying Event Number:**
**1** Employee Termination or Reduction of Work Hours
**2** Employee Death
**3** Employee Total Disability
**4** Divorce or Legal Separation
**5** Employee Eligible For Medicare
**6** Dependent No Longer Eligible

| Coverage Continuation Applies To: | Event Number | Date of Qualifying Event | Social Security Number |
|---|---|---|---|
| ☐ Employee & All Dependents Currently Enrolled | | / / | |
| ☐ Employee Only | | / / | |
| ☐ Spouse Only | | / / | - - |
| ☐ Dependent(s) Only – List Names in Part C | | / / | - - |
| ☐ Employee & Spouse | | / / | |
| ☐ Employee & Dependent Child(ren)–List Names in Part C | | / / | |

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

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

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

# Instructions for Completion of Membership Maintenance Form

## Important Notes:

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format.
- 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).
- Before submitting, review it to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned to you and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt by Delta Dental of Minnesota.

**Part A: Employee Information -** Complete all sections.

**Part B: Change Request**

- **Name Change** – Provide name as previously reported and new name.
- **Terminate Employee and All Dependents** – Only use this section if the employee and all dependent coverage is being terminated.
- **Change Employee Group/Subgroup** – Move employee from one group/subgroup to another for benefit, report or COBRA purposes.
- **For Millennium Choice Groups Change Plan Options at Open Enrollment** – Use for employees currently enrolled in Millennium Choice to select new Network during group's Open Enrollment.
- **For DeltaCare Groups Change Clinic Code** – List new clinic code found in DeltaCare Provider Directory.
- **Enroll in Voluntary Discount Orthodontic Program –** Applies only to groups offering this program.
- **Change Coverage Type, Add or Drop Dependent Due to Qualifying Event** – Complete this section to change *Coverage Type* and/or to add or drop dependent's coverage. Provide detailed information for each dependent being added or dropped in Part C.

**Part C: Dependent Information**

- List and complete all sections for each dependent to be added or dropped, if requested in Part B
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

**Part D: Employee Signature**

- Please read and sign form as verification of your change request.
- Return completed form to your benefit administrator.

**Part E: COBRA – Complete this section only if an individual has selected continuation of coverage under COBRA.**

- Select a *Coverage Type*, the appropriate *Qualifying Event Number, Date of Qualifying Event* and *Effective Date of Coverage.*
- If employee is not enrolling for COBRA, provide Social Security Number of individual who is being enrolled.
- If group has a separate COBRA subgroup, it must be provided in Part B.

**Part F: Group Information – Completed By Employer**

- **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