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