

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: <input type="checkbox"/> Name change – Previous name: _____ <input type="checkbox"/> Transfer from sublocation: _____ <input type="checkbox"/> Address change <input type="checkbox"/> Other: _____
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 _____
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			Check if Dependent under age 26	*	E-Mail for Spouse and/or Dependents Over the Age of 14
				Mo	Day	Yr			

*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? Yes No

Will this dental coverage replace another Northeast Delta Dental Plan? Yes No **If yes to either question, complete the following:**

DENTAL INSURANCE COMPANY	POLICYHOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY) — —
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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: _____