DELTA DENTAL
Delta Dental Plan of Minnesota

Membership Maintenance Form

Independent School District 196	Group/Subgroup # 476	Effective Date

Employee Last Name	First Name	MI	Employee #	Date of Birth	Social Security #

☐ **Address Change To:** _____ _____ _____ _____
Street Address/ Apt # **City** **State** **Zip**

☐ **Name Change From** _____ **To** _____

Home Phone Number

CHANGE:

Additions
☐ Add dependent(s)

Cancellations
☐ Cancel all coverage
☐ Cancel all dependent coverage only
☐ Cancel coverage only on dependent(s) listed below

REASONS FOR CHANGE:

☐ Birth of child
☐ Marriage-date_____
☐ Adoption- Date of placement/legal guardianship_____
(placement papers must accompany this form)
☐ Dependent now ineligible-date_____
☐ Divorce-date_____
☐ Death-date _____
☐ Open Enrollment
☐ Other_____

FILL IN THE FOLLOWING INFORMATION FOR EACH DEPENDENT AFFECTED BY THE CHANGE

Last Name (only if different from above)	First Name	MI	Sex (M/F)	Date of Birth	Social Security Number (required)	Relationship Spouse/Child/Other

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THE APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

SIGNATURE OF EMPLOYEE	DATE	SIGNATURE OF EMPLOYER	DATE