

Delta Dental of Minnesota Membership Maintenance Form

Delta Dental of Minnesota

PART A - EMPLOYEE INFORMATION - Employee complete Part A through Part E, as appropriate.

| | S | | | | | FIFST | | | | Milagie | | 300 | iai Seci | urity Nur | inver | |
|---|---|--|--|--|--|--|---|---|---|--|--|--|--|--|---|----------|
| Name: | | | | | | | | | | | | | | / | · | |
| Gender: | Male | Fe | male | Marital | Single | Married | Widowe | d Divorced | Legally Se | parated | | Date of | Birth (N | /lonth-Da | ay-Year) | |
| | | | | Status: | | | | | | | | | / | / | | |
| Employee' | S | Address | | | | | | | | 1 | Day Phone N | lumber | | Evening Pho | ne Number | |
| Address: | | | | | | | | | | | | | | | | |
| Check If | : | City | | | | | | State | | | | Zip Code | | | | |
| New Addre | | | | | | | | | | | | | | | | |
| PART B – C | CHANG | SE REQUES | ST - Ch | eck all categ | ories that | apply and | | e information i | | | | | | | | |
| ☐ Name (| Chang | e | | | | | □⊺ | erminate Emp | loyee a | nd All | Depende | nt Coverage | е | | | |
| Former N | lame:_ | | | | | | Date of Termin | nation:_ | | | | | | | | |
| New Nam | e: _ | | | | | | | Date Coverage | e Ends: | | /_ | | .,- | | | |
| | | | | Change Pla PPO □ Pl | | | | | | | | | | , | | |
| | | • | - | l inic Code to taCare Provi | | orv | | | | | | | | | | |
| | Enroll or Disenroll from the 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 | | | | | | | | | | | | | | | | |
| | | | | | | | | e O – Open Er | | | | | r Eligibl | е | | |
| | | | l | Coverage Ty | | | | | | | alifying E | 1 | | | of Chan | ge |
| | | | | | pe / citar | .ge neque | | , | | 1 | / | | | / | 1 | <u> </u> |
| Employee Only Employee & Spouse | | | | | | \$ | | | ', ', ' | | | 1 / / | | | | |
| | | | <u> </u> | | | L !! -! / \ | 1/ | | | ', ', | | | · · · · · · · · · · · · · · · · · · · | | | |
| | | | ļ | loyee & Dep | pendent Ci | niia(ren) | | | _ | 1 1 | | | | | | |
| Family | | | | | | | | | _ | 1 1 | | | | | | |
| <u></u> | | | | or Drop Dep | | | | ···· | | | /_ | | | / | / | |
| PART C - E | DEPEN | DENT INFO | ORMA | TION – Addi | ing or dro | oping depe | ndents | may require a | Covera | ge Typ | · | | | | ·· _{[•••} | |
| Relationship | | | n | First Name, Middle Initial | | | | Vame | | Date of Bir | | of Birth | Full Time | | | |
| | l _ | • | | | | | | | l _ | | 1 • | | 1 _ | | | |
| Add Drop | l _ | Employe | | | st Name Or | nly if Differe | nt From | Employee's) | | nder | Month | /Day/Year | Stu | dent? | Unma | rried? |
| Add Drop | l _ | • | | | st Name Or | nly if Differer | nt From | Employee's) | Ge M | nder F | Month, | /Day/Year / | Stu | dent? | Unma | rried? |
| Add Drop | То | Employe | e | | st Name Or | nly if Differen | nt From | Employee's) | | | Month, / | /Day/Year / / | Stu | dent? | Unma Y | rried? |
| Add Drop | Dep | Spouse | e nild | | st Name Or | nly if Differer | nt From | Employee's) | М | F | Month/ / / | /Day/Year / / / | | 0.5 | | |
| | Dep Dep | Spouse Dendent Ch Dendent Ch | e nild nild | (Include La | | | | Employee's) your enrollme | M M M | F F | Month | /Day/Year / / / | Υ | N | Υ | N |
| PART D - I | Dep Dep EMPLO | Spouse Spouse Dendent Ch Dendent Ch DYEE SIGN | e nild nild IATURI | (Include Las | date form | n as verifica | ition of | | M M M ent chan | F F F ge. | / | / / / | Y | N N | Y | N N |
| PART D - I | Dep Dep EMPLO e to ma | Spouse pendent Chendent Chende | e nild nild IATURI s as ind | (Include Last | date form | n as verifica authorize p | ation of | your enrollme | M M M ent chan | F F F ge. | / / is comple | / / / ted, I have e | Y Y | N N | Y Y | N N |
| PART D - I | Dep Dep EMPLO e to ma blan due er cond | Spouse Spouse Dendent Ch DYEE SIGN ake changes e to the qualitions as ma | e nild nild IATURI s as ind | (Include Last | date form | n as verifica authorize p | ation of | your enrollme | M M M ent chan | F F F ge. | / / is comple | / / / ted, I have e ion, I must m | Y Y | N N | Y Y | N N |
| PART D – I i choose under this p and/or othe Employee | Dep Dep EMPLO e to ma er cond Signa | Spouse Sp | e nild IATURI s as ind alifying ay be re | (Include La: E — Sign and icated on thi event indicated. | date form s form and ed below a | n as verifica authorize p nd I underst | ation of ayroll de and that | your enrollme eduction, if appl in order to reta | M M ent chan licable. If in my co | F F ge. Part E | / / / is comple continuat | / / / ted, I have e ion, I must m | Y Y ected to | N N o continue | Y Y | N N |
| PART D — I I choose under this p and/or othe Employee PART E — C | Dep Dep EMPLO e to ma olan due er cond Signa COBRA | Spouse Sp | e nild IATURI s as ind alifying ay be re | (Include La: E — Sign and icated on thi event indicated. | date form s form and ed below a | n as verifica authorize p nd I underst | ation of ayroll de and that | your enrollme | M M ent chan licable. If in my co | F F ge. Part E | / / / is comple continuat | / / / ted, I have e ion, I must m | Y Y ected to | N N o continue | Y Y | N N |
| PART D — I I choose under this p and/or othe Employee PART E — Q Qualifying | Dep Dep EMPLO e to ma blan duer cond Signa COBRA g Event | Spouse Sp | e nild IATURI s as ind alifying ay be re | (Include La: E — Sign and icated on thicevent indicatequired. te: Complet | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst | ation of ayroll do and that r COBR | your enrollme eduction, if appl in order to reta A benefits Em i | M M M ent chan icable. If in my co | F F ge. Part E | / / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup | Y Y Y Gected to | N N O continue payment of | Y Y Y e coverage obligations | N N |
| PART D — I I choose under this p and/or othe Employee PART E — Q Qualifying | Dep Dep EMPLO e to ma olan du er cond Signa COBRA g Event | Spouse Sp | e nild IATURI s as ind alifying ay be re | (Include La: E — Sign and icated on thi event indicated. | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst | ation of ayroll de and that r COBR | your enrollme eduction, if appl in order to reta | M M M M mt chan icable. If in my co | F F F ge. Part E verage | / / / is comple continuat | / / / ted, I have e ion, I must m | Y Y Vected treet the | N N N O continue payment of the continue payment of th | Y Y e coverage obligation: | N N |
| PART D — I I choose under this p and/or othe Employee PART E — C Qualifying 1 Employe 2 Employee | Dep Dep EMPLO e to ma blan due er cond Signa COBRA g Event ee Terriee Dea | Spouse Sp | e nild nild IATURI s as ind allfying ay be re vee No | E – Sign and icated on thi event indicat quired. | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR. 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Em p ployee Total D | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup 5 Employ | Y Y ected to eet the changee Eligi lent No | N N N O continue payment of the continue payment of th | Y Y e coverage obligation: | N N |
| PART D – I i choose under this p and/or othe Employee PART E – C Qualifying 1 Employe 2 Employe Coverage | Dep Dep EMPLC e to ma blan duer cond Signa COBRA g Event ee Terr ee Dea Contir | pendent Chechen Cheche | e nild nild IATURI s as ind alifying ay be re ree No or Redu | E – Sign and icated on thi event indicat quired. | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR. 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Em ployee Total D orce or Legal S | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup 5 Employ 6 Depend | Y Y ected to eet the changee Eligi lent No | N N N O continue payment of the continue payment of th | Y Y e coverage obligation: | N N |
| PART D — I choose under this p and/or othe Employee PART E — Qualifying 1 Employe 2 Employe Coverage | Dep Dep EMPLO e to ma blan du er cond Signar COBRA g Event ee Terr ee Dea Contir | pendent Chendent Chen | e nild nild IATURI s as ind alifying ay be re ree No or Redu | E – Sign and icated on this event indicated. te: Complet action of Wo | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR. 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Em ployee Total D orce or Legal S | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup 5 Employ 6 Depend | Y Y ected to eet the changee Eligi lent No | N N N O continue payment of the continue payment of th | Y Y e coverage obligation: | N N |
| PART D — I choose under this p and/or othe Employee PART E — Qualifying 1 Employe 2 Employe Coverage Employ | Dep Dep EMPLO e to ma blan duer cond Signa COBRA g Event ee Terre ee Dea Contin | pendent Chendent Chen | e nild nild IATURI s as ind alifying ay be re ree No or Redu | E – Sign and icated on this event indicated. te: Complet action of Wo | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR. 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Em ployee Total D orce or Legal S | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup 5 Employ 6 Depend | Y Y ected to eet the changee Eligi lent No | N N N O continue payment of the continue payment of th | Y Y e coverage obligation: | N N |
| PART D — I choose under this pand/or othe Employee PART E — Qualifying 1 Employe 2 Employe Coverage (Employ) Employ | Dep Dep EMPLO e to ma blan due er cond Signar COBRA g Event ee Tera ee Dea Contin yee & y yee On conly | Spouse Sp | e mild mild MATURI S as indalifying ay be reversed to price Not the price of the pr | E – Sign and icated on this event indicated. te: Complet action of Wo | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR. 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Em ployee Total D orce or Legal S | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup 5 Employ 6 Depend | Y Y ected to eet the changee Eligi lent No | N N N O continue payment of the continue payment of th | Y Y e coverage bligation: | N N |
| PART D — I choose under this pand/or othe Employee PART E — Qualifying 1 Employe 2 Employe Coverage (Employ) Employ | Dep Dep EMPLC e to ma blan du er cond Signa COBRA g Event ee Terr ee Dea Contir //ee & // //ee Only dent(s) | pendent Chendent Chen | e mild mild MATURI S as indalifying ay be reversed to price Notice Populies 1 dents C | E — Sign and icated on this event indicated on this event indicated on the complete complete. | date form s form and ed below a e Only if e | n as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR. 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Em ployee Total D orce or Legal S | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup 5 Employ 6 Depend | Y Y ected to eet the changee Eligi lent No | N N N O continue payment of the continue payment of th | Y Y e coverage bligation: ledicare ligible ecurity N | N N |
| PART D — I i choose under this p and/or othe Employee PART E — C Qualifying 1 Employe 2 Employe Coverage i Employ Spouse i Depend Employ | Dep Dep EMPLC e to ma blan du er cond Signa COBRA g Event ee Terr ee Dea Contir //ee & // //ee Only dent(s) //ee & S | Spouse | nild nild IATURI s as ind alifying ay be re ree No or Redu pplies T dents C | E — Sign and icated on this event indicated on this event indicated on the complete complete. | date form s form and ed below a e Only if e ork Hours | a as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR. 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Em ployee Total D orce or Legal S | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / ted, I have e ion, I must m Date: re subgroup 5 Employ 6 Depend | Y Y ected to eet the changee Eligi lent No | N N N O continue payment of the continue payment of th | Y Y e coverage bligation: ledicare ligible ecurity N | N N |
| PART D — I I choose under this pand/or othe Employee PART E — C Qualifying 1 Employe 2 Employe Coverage Employ Spouse Depend Employ Employ | Dep Dep EMPLO e to ma bolan du er cond Signa COBRA g Event ee Terr ee Dea Contir vee & vee On conly dent(s) vee & s vee & s | DEMPLOYER Spouse Dendent Ch DYEE SIGN ake changes et to the qua itions as ma ture: Number: mination counth nuation Ap All Dependent ly Only – Lis Spouse Dependent | e nild nild NATURI s as ind allfying ay be reported to populate Telephones Te | E — Sign and icated on this event indicated on this event indicated on this event indicated or indicated or indicated or indicated. To: Currently Enumer of the control o | date form s form and ed below a e Only if e ork Hours rolled | a as verifica authorize p nd I underst enrolling fo | ation of ayroll de and that r COBR 3 Em 4 Div umber | your enrollme eduction, if appl in order to reta A benefits Employee Total D orce or Legal S Date of Quality / / / | M M M ent chan icable. If in my coologer N isability eparation | F F ge. Part E verage | / / is comple continuat | / / / / / / / / / / / / tted, I have e ion, I must m Date: re subgroup 5 Employ 6 Depend Oate of Cove / / / / / / / / | Y Y Y Rected to eet the ochange ee Eligilent Noterage | N N N N N N N N N N N N N N N N N N N | Y Y e coverage bligation: ledicare ligible ecurity N | N N |
| PART D — I I choose under this p and/or othe Employee PART E— C Qualifying 1 Employe Coverage Employe Spouse Depend Employ Employ PART F— C | Dep Dep EMPLO e to ma bolan duler cond Signar COBRA g Evente ee Dea Contir yee & y yee On young dent(s) yee & S | DEMPLOYEE Spouse Dendent Checker Changes et to the qualitions as mature: - Employee Number: mination couth nuation Apall Dependent by Only – List Spouse Dependent | nild nild NATURI s as ind alifying ay be re vee No or Redu pplies 1 dents C | E – Sign and icated on this event indicated on this event indicated on the country of the control of Work of the control of the contro | date form and ed below a e Only if e ork Hours | as verifica authorize p nd I underst enrolling fo | r COBR 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Employee Total D orce or Legal S Date of Qualit / / / / / / / PLOYER | M M M M icable. If in my co | F F F ge. Part E verage | / // is comple continuat ffective I / / / / / / / / / / / / / / / / / / / | / / / / / / / / / / / / / / | Y Y Y Rected to eet the ochange ee Eligilent Noterage | N N N N N N N N N N N N N N N N N N N | Y Y e coverage bligation: | N N |
| PART D — I choose under this p and/or other temployee PART E — Qualifying 1 Employe 2 Employe Coverage Employ Spouse Depender Employ Employ PART F — Qualifying Change | Dep Dep EMPLO e to ma blanduer cond Signar COBRA g Event ee Dea Contin yee & 2 yee On conly dent(s) yee & S yee & S gray Employee | pemployee Spouse Dependen Oyle Finform Spouse Spous | nild nild NATURI s as ind alifying ay be re vee No or Redu pplies 1 dents C | E – Sign and icated on this event indicated on this event indicated on the country of the control of Work of the control of the contro | date form and ed below a e Only if e ork Hours | as verifica authorize p nd I underst enrolling fo | r COBR 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Employee Total D orce or Legal S Date of Quality / / / | M M M M icable. If in my co | F F F ge. Part E verage | / // is comple continuat ffective I / / / / / / / / / / / / / / / / / / / | / / / / / / / / / / / / / / | Y Y Y Rected to eet the ochange ee Eligilent Noterage | N N N N N N N N N N N N N N N N N N N | Y Y e coverage bligation: | N N |
| PART D — I choose under this pand/or othe Employee PART E — C Qualifying 1 Employe 2 Employe Coverage Employ Spouse Depend Employ Employ Coverage Employ Employ From: Effective Da | Dep Dep EMPLO e to ma blan duer cond Signa COBRA g Event ee Dea Contin yee & J yee On Only dent(s) yee & S | DEMPLOYEE Spouse Dendent Chendent Chend | nild nild IATURI S as ind alifying ay be re ree No or Redu pplies 1 dents C st Nam t Child ATION up/Sub o: | E — Sign and icated on this event indicated urred. te: Complet action of Work in the complet in the completion of the completion in the complet | date form and ed below a e Only if e ork Hours rolled | enrolling fo | r COBR 3 Em 4 Div | your enrollme eduction, if appl in order to reta A benefits Employee Total D orce or Legal S Date of Qualit / / / / / / / PLOYER | M M M M icable. If in my co | F F F ge. Part E verage | / // is comple continuat ffective I / / / / / / / / / / / / / / / / / / / | / / / / / / / / / / / / / / | Y Y Y Rected to eet the ochange ee Eligilent Noterage | N N N N N N N N N N N N N N N N N N N | Y Y e coverage bligation: | N N |
| PART D — I choose under this pand/or othe Employee PART E — C Qualifying 1 Employe 2 Employe Coverage Employ Spouse Depend Employ Employ Coverage Employ Employ From: Effective Da | Dep Dep EMPLO e to ma blan duer cond Signa COBRA g Event ee Dea Contin yee & J yee On Only dent(s) yee & S | DEMPLOYEE Spouse Dendent Chendent Chend | nild nild IATURI S as ind alifying ay be re ree No or Redu pplies 1 dents C st Nam t Child ATION up/Sub o: | E — Sign and icated on this event indicated urred. te: Complet action of Work in the complet in the completion of the completion in the complet | date form and ed below a e Only if e ork Hours rolled | enrolling fo | r COBR 3 Em 4 Div umber BY EM ent sub | your enrollme eduction, if appl in order to reta A benefits Emp ployee Total D orce or Legal S Date of Qualit / / / / / / PLOYER group, includir | M M M M icable. If in my cool oloyer N isability eparatic fying Ev. / / / / / / / / / / / / / / / / / / / | F F ge. Part E verage ote: N on ent E | / // is comple continuat ffective I / / / / / / / sbgroup) | / / / / / / / / / / / / / / | Y Y Y Rected to eet the eet t | N N N N N N N N N N N N N N N N N N N | Y Y e coverage bligation: | N N |
| PART D — I choose under this pand/or othe Employee PART E — C Qualifying 1 Employe 2 Employe Coverage Employ Spouse Depend Employ Employ Coverage Employ Employ From: Effective Da | Dep Dep EMPLO e to ma blan due er cond Signa COBRA g Event ee Dea Contin yee & y yee On conly dent(s) yee & S | DEMPLOYEE Spouse Dendent Chendent Chend | nild nild NATURI NATURI S as ind alifying ay be re ree No or Redu or Redu or Redu ATION up/Sub o: | E – Sign and icated on this event indicated on this event indicated uired. te: Complet iction of Work in the complet iction of Work in the complet iction of Work in the complete iction icti | date form and ed below a e Only if e ork Hours rolled | enrolling fo | r COBR 3 Em 4 Div umber BY EM ent sub | your enrollme eduction, if appl in order to reta A benefits Employee Total D orce or Legal S Date of Qualit / / / / / / / PLOYER | M M M M icable. If in my cool oloyer N isability eparatic fying Ev. / / / / / / / / / / / / / / / / / / / | F F ge. Part E verage ote: N on ent E | / // is comple continuat ffective I / / / / / / / / mbers: (| / / / / / / / / / / / / / / | Y Y Y Rected to eet the eet t | N N N N N N N N N N N N N N N N N N N | Y Y e coverage bligations Medicare Eligible ecurity N | N N |