Delta Dental of Minnesota

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Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A through E. Sign Part F or G as appropriate. Return form to your benefit administrator.

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
	City	State	Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type – Who Is Being Enrolled – Check One Box Only * If waiving coverage for employee and/or eligible family members, complete Part F.	Complete If Your Employer Offers The Voluntary Orthodontic Program
☐ Employee only* ☐ Family ☐ Employee and Spouse ☐ No Coverage* ☐ Employee and DependentChild(ren)	☐ I Elect ☐ I Do Not Elect to Participate in the Voluntary Discount Orthodontic Program

PART C – DEPENDENT INFORMATION

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/Domestic Partner		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

PART D – FOR MILLENNIUM CHOICE℠ GROUPS ONLY	**Select a Plan Option:** ☐ Plan Option I - Delta Dental PPO ☐ Plan Option II - Delta Dental Premier
PART E – FOR DeltaCare GROUPS ONLY Obtain Clinic Code from DeltaCare Provider Directory.	**Clinic Code:** ____________________ Please Note: Dental benefits are ONLY available when a clinic is chosen.

PART F – OTHER INSURANCE COVERAGE – Complete only if employee and/or eligible dependents are not being enrolled.

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier:____________________ Policy/Identification Number: ____________________

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Employee Signature: **Date:**

PART G – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: **Date:**

PART H – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date:_____/_____/_____
Prior Coverage Start Date (if applicable):_____/_____/_____
Coverage Effective Date:_____/_____/_____

☐ **Rehire** Date Lay Off Began:_____/_____/_____
Date Rehired:_____/_____/_____

☐ **Return from Leave of Absence**
Date Leave Began:_____/_____/_____
Date Returned to Work:_____/_____/_____

☐ **Existing Delta Dental Group**
Hire Date:_____/_____/_____
Prior Coverage Start Date (if applicable):_____/_____/_____
Coverage Effective Date:_____/_____/_____

☐ **Employee Change Part Time to Full Time**
Date of Status Change:_____/_____/_____
Effective Date: _____/_____/_____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date
Hire Date:_____/_____/_____
Effective Date:_____/_____/_____

☐ **Open Enrollment**
Effective Date:
_____/_____/_____

☐ **Qualifying Event or Special Enrollment Period**
Qualifying Event Reason:____________________
Hire Date:_____/_____/_____
Event Date:_____/_____/_____
Effective Date:_____/_____/_____

Group Name: ISD 271 Bloomington Public Schools **Group & Subgroup Numbers:** 000489 ---

Group Representative's Signature: **Date:** **Phone Number:** (952)681-6444

◆ Send Original Copy to Delta Dental + Retain Copy For Your Records +