DELTA DENTAL

Delta Dental of Minnesota
Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru G and return form to 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 – W ho Is Being Enrolled – Check One Box Only		~~**Complete If Your Employer Offers The Voluntary Orthodontic Program**~~
☐ Employee only*	☐ No Coverage*	~~☐ I Elect ☐ I Do Not Elect to Participate in the Voluntary Discount Orthodontic Program~~
☐ Employee and Spouse	*** If waiving coverage for employee and/or eligible family members, you must complete Part F.**	
☐ Employee and Dependent Child(ren)		
☐ Family		

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		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

Plan choice: Check the plan you wish to enroll in: (See Delta Dental Insurance handout for description and costs)

- ☐ Preventive Only ($500 benefit) available to part time employees only
- ☐ Comprehensive Single ($1200 benefit) available to part-time and full-time employees
- ☐ Comprehensive Family ($1200/person benefit) available to part-time and full-time employees

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** – Initial Group Enrollment Effective Date: ___/___/___	☐ **Rehire** - Length of Lay Off: _____ Date Rehired: ___/___/___	☐ **Employee Change Part Time to Full Time** Date of Change: ___/___/___ Effective Date: ___/___/___
☐ **Open Enrollment** Effective Date: ___/___/___	☐ **Return from Leave of Absence** Length of Leave: _____ Date Returned to Work: ___/___/___	☐ **Previously Waived Coverage** Qualifying Event Reason: _____ Event Date: ___/___/___ Effective Date: ___/___/___
☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date Hire Date: ___/___/___ Effective Date: ___/___/___	☐ **Loss of Coverage** – Employee and/or Dependent Date of Loss: ___/___/___ Effective Date: ___/___/___	

Group Name: ISD 271 Bloomington Schools **Group & Subgroup Numbers:** 489-00

Group Representative's Signature: Julie Hanson **Date:** **Phone Number:** 952 681-6440

E01 10/9/07