DELTA DENTAL

Delta Dental of Minnesota

Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E 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					Home Phone Number ( )		Work 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 B & D.

☐ Employee only*
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Family
☐ No Coverage*

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
Spouse		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

PART D – OTHER INSURANCE COVERAGE

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

Name of Carrier: _____ Policy/Identification No.: _____

☐ 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 E – 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 F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Hire**	☐ **Open Enrollment**	☐ **Loss of Coverage**
Effective Date: _____ /_____ /_____ Hire Date: _____ /_____ /_____	Effective Date: _____ /_____ /_____	Qualifying Event Reason: _____ Event Date: _____ /_____ /_____ Effective Date: _____ /_____ /_____

Group Name: Scott County	**Group & Subgroup Number: 3014**
Payroll Rep's Signature:	**Date of Entry:**