DELTA DENTAL

Delta Dental of Minnesota
Membership Maintenance Form

PART A – EMPLOYEE INFORMATION

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: ☐ **Check If New Address**	Address	Home Phone Number	Work Phone Number
	City / State / Zip Code		

PART B – CHANGE REQUEST - Check all categories that apply and provide information requested by category.

Name Change	**Terminate Employee and All Dependent Coverage**
Former Name:_____ New Name: _____	Date of Termination: ____/____/____

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** – Divorce/Legal Separation **E** – Death **L** – Loss of Coverage **M** – Marriage **O –** Open Enrollment **S –** Dependent No Longer Eligible

Qualifying Event Code	Coverage Type / Change Request Category	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Child(ren)	/ /	/ /
	Family	/ /	/ /
	Add or Drop Dependent - No Coverage Type Change	/ /	/ /

PART C – DEPENDENT INFORMATION – Adding or dropping dependents may require a Coverage Type change in Part B.

Add	Drop	Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender M	Gender F	Date of Birth MM/DD/YYYY
		Spouse				/ /
		Dependent Child				/ /
		Dependent Child				/ /

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

I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated below and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

Employee Signature:	**Date:**

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

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