



Delta Dental of Minnesota

### Delta Dental of Minnesota 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 <input type="checkbox"/>	Female <input type="checkbox"/>	Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Legally Separated <input type="checkbox"/>
Date of Birth (Month-Day-Year)		Address		Day Phone Number		Evening Phone Number		
City		State		Zip Code				

#### PART B – ENROLLMENT INFORMATION

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

#### 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

<b>PART D – FOR MILLENNIUM CHOICE<sup>SM</sup> GROUPS ONLY</b>	<b>Select a Plan Option:</b> <input type="checkbox"/> Plan Option I - Delta Dental PPO <input type="checkbox"/> Plan Option II - Delta Dental Premier
<b>PART E – FOR DeltaCare<sup>SM</sup> GROUPS ONLY</b> Obtain Clinic Code from DeltaCare Provider Directory.	<b>Clinic Code:</b> _____ 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

<input type="checkbox"/> <b>New Group</b> Hire Date: _____/_____/_____ Prior Coverage Start Date (if applicable): _____/_____/_____ Coverage Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Rehire Date Lay Off Began:</b> _____/_____/_____ Date Rehired: _____/_____/_____
<input type="checkbox"/> <b>Existing Delta Dental Group</b> Hire Date: _____/_____/_____ Prior Coverage Start Date (if applicable): _____/_____/_____ Coverage Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Return from Leave of Absence</b> Date Leave Began: _____/_____/_____ Date Returned to Work: _____/_____/_____
<input type="checkbox"/> <b>New Hire – Apply Probationary Period (if applicable) to determine Effective Date</b> Hire Date: _____/_____/_____ Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Employee Change Part Time to Full Time</b> Date of Status Change: _____/_____/_____ Effective Date: _____/_____/_____
<input type="checkbox"/> <b>Open Enrollment</b> Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Qualifying Event or Special Enrollment Period</b> 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) 1681-6444

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

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