DELTA DENTAL®

Delta Dental Plan of Maine
Delta Dental Plan of New Hampshire
Delta Dental Plan of Vermont

ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY – IN BLUE OR BLACK INK ONLY
AS YOUR ID CARD IS GENERATED FROM THIS FORM

Please send form to:

One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800-537-1715
(603)223-1230 Eligibility
(603)223-1252 Eligibility Fax
Web site: www.nedelta.com

1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. #	GENDER	DATE OF BIRTH (MM-DD-YYYY)
		— —	☐ M ☐ F	

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ Other _____

2. GROUP INFORMATION - To be completed by Employer/Employee

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP		
GROUP NUMBER	**SUBLOCATION NUMBER**	**DIVISION**	**DENTAL EFFECTIVE DATE**
MISC. INFO (i.e. STORE LOC)	**EMPLOYEE DATE OF HIRE**	**EMPLOYEE DATE OF REHIRE**	

3. REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: _____

ADD:

- ☐ New Enrollment
- ☐ Annual Open Enrollment
- ☐ COBRA Due to: _____
- ☐ Marriage
- ☐ Birth ☐ Age Two
- ☐ Adoption*
- ☐ Spouse's employment change
- ☐ Part-time to full-time status

DELETE:

- ☐ Annual Open Enrollment
- ☐ Spouse's employment change
- ☐ Full-time to part-time status
- ☐ Divorce
- ☐ Deceased
- ☐ No longer dependent for IRS purposes
- ☐ No longer a full-time student
- ☐ Retirement

MISCELLANEOUS CHANGE:

- ☐ Name change – Previous name: _____
- ☐ Transfer from sublocation _____
- ☐ Address change
- ☐ Returning Full-Time Student
- ☐ Other _____

COVERAGE LEVEL REQUESTED:

- ☐ Employee (only) ☐ Employee/Children
- ☐ Employee/Spouse ☐ Employee/Family
- ☐ Employee/Child ☐ Other _____

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	GENDER M/F	RELATION TO SUBSCRIBER	ADD / DELETE	CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT	CHECK IF DEPENDENT IS INCAPACITATED*

***NOTE: Legal documentation is required.**

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? ☐ Yes ☐ No
Will this dental coverage replace another Northeast Delta Dental Plan? ☐ Yes ☐ No

If yes to either question, complete the following:

DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE
DENTAL INSURANCE COMPANY	**POLICY HOLDER ID # / SOCIAL SECURITY #**	**EFFECTIVE DATE**

I certify that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any dental premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change.

SIGNATURE _____ DATE _____