DELTA DENTAL®

Dental Flex Membership Enrollment Form

Delta Dental of Minnesota

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru D 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 (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 any eligible family members, you must complete Part D.**	
☐ 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

PART D – EMPLOYEE SIGNATURE – Select One

☐ 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.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions where applicable. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages.

Employee Signature: **Date:**

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

☐ **New Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Dental Flex Coverage Effective Date: _____/_____/_____

☐ **Existing Delta Dental Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Dental Flex Coverage Effective Date: _____/_____/_____

☐ **Rehire**
Date Lay Off Began: _____/_____/_____
Date Rehired: _____/_____/_____

☐ **Return from Leave of Absence**
Date Leave Began: _____/_____/_____
Date Returned to Work: _____/_____/_____

☐ **Employee Change Part Time to Full Time**
Date of Status Change: _____/_____/_____
Effective Date: _____/_____/_____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date
Hire Date: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Loss of Coverage** – Employee and/or Dependent
Hire Date: _____/_____/_____
Date of Loss: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Previously Waived Coverage**
Qualifying Event Reason: _____
Hire Date: _____/_____/_____
Event Date: _____/_____/_____
Effective Date: _____/_____/_____

Group Name: **Group & Subgroup Numbers**: ---

Group Representative's Signature: **Date:** **Phone Number:** ( )

www.deltadentalmn.org

◆ Send Original Copy to Delta Dental◆ Retain Copy For Your Records ◆ E10 1/26/09

Employer Instructions

- Review Parts A, B, C, and D to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Delta Dental of Minnesota generally completes enrollment requests within five business days of receipt.

Employer Complete Part: E - Group Enrollment Information

- Review sections completed by employee to assure information provided is complete, accurate and legible.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer to Delta Dental and submitting initial employee enrollment. Complete all dates:
    - Hire Date – date employee was employed by group
    - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Date does not apply if group did not previously have a qualified dental plan. When applicable, provide date employee enrolled in group's prior dental plan.
- **Existing Delta Dental Group** – Existing Delta Dental customer changing benefits to Dental Flex product and submitting employee enrollment.
    - Hire Date – date employee was employed by group
    - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Date does not apply if group did not previously have a qualified dental plan. When applicable, provide date employee enrolled in group's prior dental plan
- **New Hire** – Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was laid off and is being rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Previously Waived Coverage** – Enrolled employee had eligible family status change such as: marriage, divorce, birth, adoption, which allows dependents to be added.
- **Employee Status Change** – Employee's employment status changed and employee is now eligible for dental benefits.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Forms To:
Delta Dental of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis MN 55440-0330