DELTA DENTAL

Group Plan Enrollment/Change Form

Please email an electronic copy of your completed form to groupadmin@deltadentalnm.com

☐ Dental Only ☐ Vision Only ☐ Dental and Vision

Part A – Employee/Employer Information

Employee Name (last, first, middle initial)	Gender M ☐ F ☐	Married? Y ☐ N ☐	Social Security Number ___ ___ ___-___ ___-___ ___ ___ ___	Date of Birth (mm/dd/yy) ___ ___/___ ___/___ ___ ___ ___
Name of Employer	Group Number		Employee's Work Site Location/Branch	Date of Hire (mm/dd/yy) ___ ___/___ ___/___ ___ ___ ___
Employee Position/Title			Do you have other dental and/or vision benefits? Y ☐ N ☐ Name of other plan(s), if applicable: ____________	
Home Mailing Address (including city, state, ZIP Code)				☐ Check here if new address

Part B – Enrollment or Other Action Required

☐ **Enroll in Dental Plan**
Enrollee Category
☐ Active Employee
☐ Retiree
☐ COBRA

☐ **Enroll in Vision Plan**
Enrollee Category
☐ Active Employee
☐ Retiree
☐ COBRA

Network or high/low plan option, if applicable: ____________

☐ **Waive Dental Coverage**
☐ **Waive Vision Coverage**
If you are waiving coverage, please complete and sign Part F below.

☐ **Cancel Employee Coverage:** ☐Dental ☐Vision ☐Dental/Vision (also cancels dependent coverage, if applicable)
☐ **Add Dependents** (list in Part C new Eligible Dependents to be covered)
☐ **Cancel Dependent Coverage:** ☐Dental ☐Vision ☐Dental/Vision
☐ On all Enrolled Dependents
☐ On dependent(s) listed here: ____________

Coverage Change for (choose one): ☐ Dental Only ☐ Vision Only ☐ Dental and Vision

Coverage Effective/Change/Coverage Termination Date: ____________ **Reason for Action (At least one box must be checked. Check all that apply.):**

☐ **New Hire**
☐ **Initial or Open Enrollment**
☐ **Change of Status Date:** ____________
☐ **Marriage Date:** ____________
☐ **Divorce Date:** ____________

☐ **Birth** ☐ **Adoption Date:** ____________
☐ **Termination of Employment Date:** ____________
☐ **Loss of Eligibility Due to:** ☐ **Retirement** ☐ **Age**
☐ **Other Loss of Eligibility:** ____________
☐ **Submit Supporting Documentation of Qualifying Event**

☐ **Death Date:** ____________
☐ **Change of Address**
☐ **Other:** ____________

Part C – Dependent Information (For additional dependents, please attach a separate sheet.)

Coverage	Dependent Name	Gender / Relationship	Social Security Number	Date of Birth (mm/dd/yy)
☐ Dental ☐ Vision ☐ Dental/Vision	Dependent Name	Gender M ☐ F ☐	___ ___ ___-___ ___-___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
		Relationship	Does he/she have other dental/vision benefits? Y ☐ N ☐ Name of other plan, if applicable: ____________	
☐ Dental ☐ Vision ☐ Dental/Vision	Dependent Name	Gender M ☐ F ☐	___ ___ ___-___ ___-___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
		Relationship	Does he/she have other dental/vision benefits? Y ☐ N ☐ Name of other plan, if applicable: ____________	
☐ Dental ☐ Vision ☐ Dental/Vision	Dependent Name	Gender M ☐ F ☐	___ ___ ___-___ ___-___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
		Relationship	Does he/she have other dental/vision benefits? Y ☐ N ☐ Name of other plan, if applicable: ____________	
☐ Dental ☐ Vision ☐ Dental/Vision	Dependent Name	Gender M ☐ F ☐	___ ___ ___-___ ___-___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
		Relationship	Does he/she have other dental/vision benefits? Y ☐ N ☐ Name of other plan, if applicable: ____________	

Part D – Signature for Enrollment and Change of Status

If enrolled, I agree to make the required contribution as stated in the Group Dental Insurance Contract and/or Group Vision Insurance Contract and to repay promptly any benefit payments to which I or my dependents were not entitled. I certify that the information contained in this form is true and correct to the best of my knowledge. **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.**

Signature: ____________ Date: ____________

Part E – For Delta Dental Use Only

Group Number: ____________ **Effective Date of Enrollment and/or Change:** ____________ **Termination Date:** ____________

Part F – Waiver of Coverage: Sign here only if you are waiving Delta Dental coverage.

I hereby decline coverage because: ☐ I have other dental/vision coverage. If other coverage, who is your current carrier? ____________
☐ Other reason for waiver: ____________

I understand that future enrollment of myself or my dependent(s) is subject to the eligibility requirements of my employer's dental and/or vision Plan. **Please check with your Group Plan Administrator to see if the Plan allows for a future Open Enrollment period.**

Signature: ____________ **Date:** ____________