DELTA DENTAL®

800-537-1715 Corporate • 603-223-1230 Eligibility • 603-223-1252 Eligibility Fax

Delta Dental Plan of Vermont, Inc.

DENTAL ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY – IN BLUE OR BLACK INK ONLY

Please send form to:
Northeast Delta Dental
PO Box 2002
Concord, NH 03302-2002
Web site: www.nedelta.com

1. SUBSCRIBER INFORMATION - To be completed by Employee

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

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED / CIVIL UNION PARTNER ☐ DIVORCED ☐ WIDOWED ☐ OTHER _____

E-MAIL

2. GROUP INFORMATION

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP

GROUP NUMBER	SUBLOCATION NUMBER	DIVISION	MISC. INFO (i.e. STORE LOC)

EFFECTIVE DATE (MM-DD-YYYY)	EMPLOYEE DATE OF HIRE (MM-DD-YYYY)	EMPLOYEE DATE OF REHIRE (MM-DD-YYYY)
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3. REASON FOR ENROLLMENT/CHANGE:

EXACT DATE OF STATUS CHANGE _____ – – (MM-DD-YYYY)

ADD:
- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ COBRA Due to:
- ☐ Marriage/Civil union
- ☐ Birth ☐ Other:
- ☐ Adoption
- ☐ Employment change for spouse/civil union partner
- ☐ Part-time to full-time employment status

DELETE:
- ☐ Annual open enrollment
- ☐ Employment change for spouse/civil union partner
- ☐ Full-time to part-time employment status
- ☐ Divorce/Termination of a civil union
- ☐ Deceased
- ☐ No longer dependent for IRS purposes
- ☐ Retirement
- ☐ Other_____

MISCELLANEOUS CHANGE:
- ☐ Name change – Previous name: _____
- ☐ Transfer from sublocation: _____
- ☐ Address change
- ☐ Other: _____

COVERAGE LEVEL REQUESTED
☐ Employee Only ☐ Employee & Spouse/Civil union partner ☐ Employee & Child ☐ Employee & Children ☐ Family

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)	First Name	M.I.	Relationship To Subscriber	Date Of Birth Mo	Day	Yr	Check if Dependent under age 26	*	E-Mail for Spouse and/or Dependents Over the Age of 14

***Check if dependent is incapacitated. Legal documentation may be required.**

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse/civil union partner, or any dependent be covered under any other group 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	POLICYHOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY)
		– –

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider 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 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. **By signing below I hereby accept coverage.**

This policy provides dental benefits only. Review your policy carefully.

SIGNATURE (REQUIRED): _____ DATE: _____