DELTA DENTAL

Pathfinder DENTAL

Membership Enrollment Form

Delta Dental of Minnesota

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E 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			Day Phone Number		Evening Phone Number	
	City		State	Zip Code			

PART B – ENROLLMENT INFORMATION

Select Coverage Type – W ho Is Being Enrolled – Check One Box Only

☐ Employee only*
☐ Employee and Spouse
☐ Employee and Dependent Child(ren)
☐ Family
☐ No Coverage*

*** If waiving coverage for employee and/or any eligible family members, you must complete Part D.**

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	If Over Age 19, Full-Time Student?
Spouse		M	F	/ /	
Dependent Child		M	F	/ /	☐ Yes ☐ No
Dependent Child		M	F	/ /	☐ Yes ☐ No
Dependent Child		M	F	/ /	☐ Yes ☐ No

PART D – OTHER INSURANCE COVERAGE – Complete 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 E – 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 F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group** – Initial Group Enrollment Effective Date: _____/_____/_____	☐ **Rehire** - Length of Lay Off:_____ Date Rehired:_____/_____/_____	☐ **Other** - Reason:_____ Effective Date: _____/_____/_____
☐ **Open Enrollment** Effective Date:_____/_____/_____	☐ **Return from Leave of Absence** Length of Leave: _____ Date Returned to Work:____/_____/_____	☐ **Employee Change Part Time to Full Time** Date of 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 Date of Loss: _____ /_____/_____ Effective Date: _____ /_____/_____	☐ **Previously Waived Coverage** Qualifying Event Reason:_____ Event Date: _____ /_____/_____ Effective Date: _____/_____/_____

Group Name: City of Willmar **Group & Subgroup Numbers**: 595145

Group Representative's Signature: **Date:** **Phone Number:** (320) 235-4913