



Delta Dental of Minnesota Membership Maintenance Form

PART A - EMPLOYEE INFORMATION

Employee's Name:		Last		First		Middle Initial		Social Security Number	
		/		/				/	
Gender:	Male	Female	Marital Status:		Single	Married	Widowed	Divorced	Legally Separated
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date of Birth (Month-Day-Year)						/ /	
Employee's Address:		Address				Day Phone Number		Evening Phone Number	
<input type="checkbox"/> Check If New Address		City				State		Zip Code	

PART B - CHANGE REQUEST - Check all categories that apply and provide information requested by category.

<input type="checkbox"/> Name Change Former Name: _____ New Name: _____	<input type="checkbox"/> Terminate Employee and All Dependent Coverage Date of Termination: ____/____/____ Date Coverage Ends: ____/____/____		
<input type="checkbox"/> Change Employee Group/Subgroup (Move individual to different subgroup, including to COBRA subgroup) From: _____ To: _____ Effective Date of Change: ____/____/____	<input type="checkbox"/> Millennium Choice Groups Change Plan Option at Open Enrollment <input type="checkbox"/> Plan Option I - Delta Dental PPO <input type="checkbox"/> Plan Option II - Delta Dental Premier <input type="checkbox"/> For DeltaCare Groups Change Clinic Code to: _____ Obtain Clinic Code from DeltaCare Provider Directory		
<input type="checkbox"/> Enroll in Voluntary Discount Orthodontic Program			
<input type="checkbox"/> Change Coverage Type, Add or Drop Dependent Due to Qualifying Event – List Qualifying Event Code next to correct Coverage Type/Change Request Category. Complete Part C if Adding or Dropping Dependent(s). Qualifying Event Code: A – Adoption B – Birth D – Divorce/Legal Separation E – Death L – Loss of Coverage M – Marriage O – Open Enrollment S – Dependent No Longer Eligible			
Qualifying Event Code	Coverage Type / Change Request Category	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /
	Add or Drop Dependent - No Coverage Type Change	/ /	/ /

PART C - DEPENDENT INFORMATION – Adding or dropping dependents may require a Coverage Type change in Part B.

Add Drop	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?	
			M	F		Y	N	Y	N
	Spouse		M	F	/ /				
	Dependent Child		M	F	/ /	Y	N	Y	N
	Dependent Child		M	F	/ /	Y	N	Y	N

PART D - EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment change.

I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated below and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

Employee Signature: _____ **Date:** _____

PART E - COBRA - Employee Note: Complete Only if enrolling for COBRA benefits Employer Note: May require subgroup change.

Qualifying Event Number:

1 Employee Termination or Reduction of Work Hours	3 Employee Total Disability	5 Employee Eligible For Medicare
2 Employee Death	4 Divorce or Legal Separation	6 Dependent No Longer Eligible

Coverage Continuation Applies To:	Event Number	Date of Qualifying Event	Social Security Number
<input type="checkbox"/> Employee & All Dependents Currently Enrolled		/ /	
<input type="checkbox"/> Employee Only		/ /	
<input type="checkbox"/> Spouse Only		/ /	- -
<input type="checkbox"/> Dependent(s) Only – List Names in Part C		/ /	- -
<input type="checkbox"/> Employee & Spouse		/ /	
<input type="checkbox"/> Employee & Dependent Child(ren)–List Names in Part C		/ /	

PART F - GROUP INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

Group Name: _____	Group & Subgroup Numbers: _____
Group Representative's Signature: _____	Date: _____ Phone Number: _____