BlueCross BlueShield Minnesota

DELTA DENTAL

A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM – INSTRUCTIONS FOR CHANGES ON PAGE 2

Employee's Last name	First name	M.I.	Date of Birth	Social Security Number	Home phone ( )
Employee's Home address	Street	City	State	Zip code	Work phone ( )

Employee's Email address

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)

Relation (Circle)	Last name	First name	M.I	Cancel Eff. Date	Add/ Cancel	Sex (Circle)	Marital status	Social Security #	Birth Date (Mo. Day Yr.)	Primary Care Clinic #
Self					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Spouse					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			

C. BENEFIT SELECTION – CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE

☐ Elect or ☐ Waive Health (self)
☐ Elect or ☐ Waive Health (dependents)
☐ Elect or ☐ Waive Dental (self)
☐ Elect or ☐ Waive Dental (dependents)
☐ Elect or ☐ Waive Supplemental Life (Benefit chosen $__________________)
☐ Elect or ☐ Waive STD
☐ Elect or ☐ Waive LTD
☐ Elect or ☐ Waive Life/AD&D (self)
☐ Elect or ☐ Waive Life/AD&D (self with dependent life coverage)

Health plan product name:

Dental plan product name:

Beneficiary	Full Name	Date of Birth	Relationship
Primary			
Contingent			

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X

Signature of employee

Month Day Year

Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):	Employee occupation:	Hours worked per week:

Monthly salary (Complete only if applying for salary-based benefits) $ ________________________

Indicate the reason employee is enrolling for coverage:

☐ New employee
☐ Rehire (length of layoff) ___________
☐ New group
☐ Return from leave of absence (length of absence) ______________________________
☐ Previously waived coverage
☐ Change from part-time to full-time
☐ Certificate of coverage termination
☐ Other ______________________________________

Date of event: ______________________________

Group numbers:

Health _______________ Dental _______________ Life _______________ STD _______________ LTD _______________

Department number __________________ Class ____

I certify the above information to be true and correct.

Signature ____ Date ______________________________

Employer name	Telephone number ( )	Fax number ( )

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E. MEDICARE AND OTHER COVERAGE INFORMATION

Will you, or any person listed above be covered by other health insurance or Medicare while enrolled under this coverage?
☐ Yes ☐ No

If yes, you must complete the following: (Medicare: List both Part A and B effective dates)

Name of policy holder	Insurance company and address	Medicare or policy #	Type of coverage (Single or Family)	Effective date

If Medicare: check reason for entitlement: ☐ Age ☐ Disability ☐ End-Stage Renal Disease
☐ Disability & Current End-Stage Renal Disease

G. COVERAGE CHANGE INFORMATION – CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B and C

Adding dependents: Date of event
☐ Birth/adoption ______
☐ Court order ______
☐ Marriage ______ County ______
☐ Other ______ Details ______

Cancelling dependents: Date of event
☐ Divorce ______
☐ Other (explain) ______

Loss of prior health and/or dental coverage:
Did you lose health coverage, dental coverage or both? ______

Date of event
☐ Other coverage voluntarily terminated ______
☐ Group continuation (COBRA) period exhausted ______
☐ Employer contribution for coverage terminated ______
☐ Coverage terminated due to loss of eligibility ______

☐ Address change
☐ Primary care clinic change
☐ Phone number change
☐ Name change

Reason ______

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

Blue Cross and Blue Shield of Minnesota and Blue Plus
P.O. Box 64024
St. Paul, Minnesota
55164-0024

Delta Dental of Minnesota is an independent company that does not provide Blue Cross and Blue Shield products and is solely responsible for their dental products.
Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.