



Dental Benefits Enrollment/Coverage Status Form

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

Part A - Employee/Employer Information

Employee Name (last, first, middle initial)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Married? Y <input type="checkbox"/> N <input type="checkbox"/>	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 benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan, if applicable: _____	
Home Mailing Address (including city, state, ZIP Code)				<input type="checkbox"/> Check here if new address

Part B - Enrollment or Other Action Required

<input type="checkbox"/> Enroll in Dental Plan Enrollee Category <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA Network Selection, if applicable to your plan: _____	<input type="checkbox"/> Waive Coverage: Please complete and sign Part F below.	<input type="checkbox"/> Cancel Employee Coverage (also cancels dependent coverage, if applicable) <input type="checkbox"/> Add Dependents (list new Eligible Dependents to be covered in Part C) <input type="checkbox"/> Cancel Dependent Coverage <input type="checkbox"/> On all Enrolled Dependents <input type="checkbox"/> On dependent(s) listed here: _____
Coverage Effective/Change/Coverage Termination Date: _____ Reason for Action (At least one box must be checked. Check all that apply.): <input type="checkbox"/> New Hire <input type="checkbox"/> Initial or Open Enrollment <input type="checkbox"/> Change of Status Date: _____ <input type="checkbox"/> Marriage Date: _____ <input type="checkbox"/> Divorce Date: _____		
<input type="checkbox"/> Birth <input type="checkbox"/> Adoption Date: _____ <input type="checkbox"/> Termination of Employment Date: _____ <input type="checkbox"/> Loss of Eligibility due to: <input type="checkbox"/> Retirement <input type="checkbox"/> Age <input type="checkbox"/> Other Loss of Eligibility: _____ <input type="checkbox"/> Submit Supporting Documentation of Qualifying Event		
<input type="checkbox"/> Death Date: _____ <input type="checkbox"/> Change of Address <input type="checkbox"/> Other: _____		

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

Dependent to be enrolled (last, first, middle initial)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Social Security Number ____-____-____	Date of Birth (mm/dd/yy) ____/____/____
Relationship		Does he/she have other dental benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan, if applicable: _____	
Dependent to be enrolled (last, first, middle initial)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Social Security Number ____-____-____	Date of Birth (mm/dd/yy) ____/____/____
Relationship		Does he/she have other dental benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan, if applicable: _____	
Dependent to be enrolled (last, first, middle initial)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Social Security Number ____-____-____	Date of Birth (mm/dd/yy) ____/____/____
Relationship		Does he/she have other dental benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan, if applicable: _____	
Dependent to be enrolled (last, first, middle initial)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Social Security Number ____-____-____	Date of Birth (mm/dd/yy) ____/____/____
Relationship		Does he/she have other dental benefits? Y <input type="checkbox"/> N <input type="checkbox"/> 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 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 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 Plan. Please check with your Group Plan Administrator to see if your Plan allows for a future Open Enrollment period.

Signature: _____ Date: _____