DELTA DENTAL

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 ☐ F ☐	Married? Y ☐ N ☐	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 ☐ N ☐ Name of other plan, if applicable: ________	
Home Mailing Address (including city, state, ZIP Code)				☐ Check here if new address

Part B – Enrollment or Other Action Required

☐ **Enroll in Dental Plan**

Enrollee Category

☐ Active Employee

☐ Retiree

☐ COBRA

Network Selection, if applicable to your plan: ________

☐ **Waive Coverage: Please complete and sign Part F below.**

☐ **Cancel Employee Coverage (also cancels dependent coverage, if applicable)**

☐ **Add Dependents (list new Eligible Dependents to be covered in Part C)**

☐ **Cancel Dependent Coverage**

☐ On all Enrolled Dependents

☐ 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.):**

☐ **New Hire**

☐ **Initial or Open Enrollment**

☐ **Change of Status** **Date:**________

☐ **Marriage** **Date:** ________

☐ **Divorce** **Date:** ________

☐ **Birth** ☐ **Adoption** **Date:** ________

☐ **Termination of Employment** **Date:** ________

☐ **Loss of Eligibility due to:** ☐ **Retirement** ☐ **Age**

☐ **Other Loss of Eligibility:** ________

☐ **Submit Supporting Documentation of Qualifying Event**

☐ **Death** **Date:** ________

☐ **Change of Address**

☐ **Other:** ________

____

____

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

Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___ ___ ___-___ ___ - ___ ___ ___ ___	Date of Birth (mm/dd/yy) ___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	
Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___ ___ ___-___ ___ - ___ ___ ___ ___	Date of Birth (mm/dd/yy) ___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	
Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___ ___ ___-___ ___ - ___ ___ ___ ___	Date of Birth (mm/dd/yy) ___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	
Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___ ___ ___-___ ___ - ___ ___ ___ ___	Date of Birth (mm/dd/yy) ___ ___/___ ___/___ ___ ___ ___
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ 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:**________