



# Group Plan Enrollment/Change Form

Please email an electronic copy of your completed form to [groupadmin@deltadentalnm.com](mailto:groupadmin@deltadentalnm.com)

Dental Only     Vision Only     Dental and Vision

## 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 and/or vision benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan(s), 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 <i>Enrollee Category</i> <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	<input type="checkbox"/> Enroll in Vision Plan <i>Enrollee Category</i> <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	<input type="checkbox"/> Waive Dental Coverage <input type="checkbox"/> Waive Vision Coverage If you are waiving coverage, please complete and sign Part F below.	<input type="checkbox"/> Cancel Employee Coverage: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Vision (also cancels dependent coverage, if applicable) <input type="checkbox"/> Add Dependents (list in Part C new Eligible Dependents to be covered) <input type="checkbox"/> Cancel Dependent Coverage: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Vision <input type="checkbox"/> On all Enrolled Dependents <input type="checkbox"/> On dependent(s) listed here: _____
Network or high/low plan option, if applicable: _____			
Coverage Change for (choose one): <input type="checkbox"/> Dental Only <input type="checkbox"/> Vision Only <input type="checkbox"/> Dental and Vision			
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"/> Birth <input type="checkbox"/> Adoption    Date: _____	<input type="checkbox"/> Death    Date: _____
<input type="checkbox"/> Initial or Open Enrollment		<input type="checkbox"/> Termination of Employment    Date: _____	
<input type="checkbox"/> Change of Status    Date: _____		<input type="checkbox"/> Loss of Eligibility Due to: <input type="checkbox"/> Retirement <input type="checkbox"/> Age	
<input type="checkbox"/> Marriage    Date: _____		<input type="checkbox"/> Other Loss of Eligibility: _____	
<input type="checkbox"/> Divorce    Date: _____		<input type="checkbox"/> Submit Supporting Documentation of Qualifying Event    _____	

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

<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Vision	Dependent Name	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/vision benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan, if applicable: _____	
<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Vision	Dependent Name	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/vision benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan, if applicable: _____	
<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Vision	Dependent Name	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/vision benefits? Y <input type="checkbox"/> N <input type="checkbox"/> Name of other plan, if applicable: _____	
<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Vision	Dependent Name	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/vision 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/or Group Vision 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/vision 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 and/or vision Plan. Please check with your Group Plan Administrator to see if the Plan allows for a future Open Enrollment period.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_