Group Plan Enrollment/Change Form – Delta Dental Plan of New Mexico

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

Part A1 – Employee/Employer Information

First:	Select applicable: ☐ Enroll ☐ Terminate ☐ New Hire ☐ Initial / Open Enrollment ☐ Change of Status - Date: ______ ☐ Enroll COBRA ☐ Retiree ☐ Waive (Complete Part D)	Mailing Address: Change in Address? ☐ Y ☐ N
Last: Middle:		City:
Date of Birth:	Date of Hire:	State:
Social Security Number:	Eligibility Effective Date:	Zip:
Group Name: Sub-Group Name:		Email: Phone:

Part B1 – Dependent Information (For additional dependents, please complete backside.)

First:	Relationship: ☐ Spouse / ☐ Domestic Partner
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______
First:	Relationship: ☐ Child ☐ Overage Child? (Attach supporting documents)
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______
First:	Relationship: ☐ Child ☐ Overage Child? (Attach supporting documents)
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______
First:	Relationship: ☐ Child ☐ Overage Child? (Attach supporting documents)
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______

Part C1 – Signature for Enrollment, Change of Status, and Communication Preferences

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. I acknowledge that Delta Dental may use my phone number and email for communications and quality surveys. I can edit my communication preferences in the Member Portal at any time.

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 D – Waiver of Coverage (Sign here only if you are waiving Delta Dental coverage)

I hereby decline coverage because:

☐ I have other dental coverage. Current carrier(s): ______

☐ 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 the Plan allows for a future Open Enrollment period.

Signature:	Date:

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Part A2 – Employee Information (For additional dependents, please complete below.)

First:	Last:	Middle:

Part B2 – Additional Dependents - Dependent Information

First:	Relationship: ☐ Child
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______________________
First:	Relationship: ☐ Child
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______________________
First:	Relationship: ☐ Child
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______________________
First:	Relationship: ☐ Child
Last: Middle:	☐ Enroll in Dental Plan ☐ Terminate from Dental Plan ☐ Enroll COBRA
Date of Birth:	
Social Security Number:	Eligibility Effective Date: ______________________

Part C2 – Signature for Enrollment, Change of Status, and Contact Information

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. I acknowledge that Delta Dental may use my phone number and email for communications and quality surveys. I can edit my communication preferences in the Member Portal at any time.

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Signature:	Date: