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

DELTA DENTAL

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

Internal Use Only – Group Number:________________ Effective Date of Enrollment and/or Change: __________________ Termination Date: ____________________

No person will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, age, race, color, national origin, gender identity, sex, or sexual orientation, religion, or other legally protected status.

Part A – Employee/Employer Information

Employee Name (last, first, middle initial):____________________________________ **Social Security Number:** _________________________ **Date of Birth (MM/DD/YYYY):**________________________

Married? ☐ Y ☐ N **Home Mailing Address (including city, state, ZIP Code):** ____ **New Address?** ☐ Y ☐ N

Other Coverage? ☐ Y ☐ N If yes, list plan(s): _____________________ **Name of Employer:**____ **Group Number:** ______________________

Employee Work Site Location/Branch:______________________________ **Date of Hire (MM/DD/YYYY):** _____________________ **Employee Position/Title:** _____________________________________

Part B – Enrollment or Other Action Required

☐ Enroll in Dental Plan **Enrollment Status:** ☐ Active Employee ☐ Retiree ☐ COBRA **Plan Option (if applicable):**_________________________________ ☐ Waive Dental Plan (fill out Part E)

Cancel Coverage for: ☐ Employee and Enrolled Dependents *or* ☐ All Enrolled Dependents *or* ☐ Enrolled Dependents listed here: ____

Add Dependents: List in Part C New Eligible Dependents to be covered.

Coverage Change:

Coverage Effective/Change/Coverage Termination Date: ____**Reason for Action (Check all that apply below):**

☐ New Hire ☐ Initial or Open Enrollment ☐ Change of Status Date: ________________ Description:_________________________________ ☐ Other: ____________________________________

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

Dependent Name (last, first, middle initial):____ **Social Security Number:**____________________________

Date of Birth (MM/DD/YYYY):_______________________ **Relationship:** __________________________ **Other Coverage?** ☐ Y ☐ N If yes, list plan(s): __________________________

Dependent Name (last, first, middle initial):____ **Social Security Number:**____________________________

Date of Birth (MM/DD/YYYY):_______________________ **Relationship:** __________________________ **Other Coverage?** ☐ Y ☐ N If yes, list plan(s): __________________________

Dependent Name (last, first, middle initial):____ **Social Security Number:**____________________________

Date of Birth (MM/DD/YYYY):_______________________ **Relationship:** __________________________ **Other Coverage?** ☐ Y ☐ N If yes, list plan(s): __________________________

Dependent Name (last, first, middle initial):____ **Social Security Number:**____________________________

Date of Birth (MM/DD/YYYY):_______________________ **Relationship:** __________________________ **Other Coverage?** ☐ Y ☐ N If yes, list plan(s): __________________________

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 – 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:** _____

Part F – Delta Dental Communications and Surveys

Texting: By listing my cellular phone or landline telephone number below, I authorize Delta Dental of New Mexico (Delta Dental) or its authorized agents to call or send SMS text messages to the phone number listed. Delta Dental may call or text me at the number listed below to provide or seek information related to my dental benefits, including oral health news, product developments, service enhancements, and quality surveys. I understand that text messaging is not a secure form of communication, and there may be inherent risks when submitting sensitive or personal information via text messaging. Standard text messaging rates and fees from my mobile carrier may apply.

[Email: By listing my email address below, I authorize Delta Dental or its authorized agents to send me information via email. Delta Dental may email me at the email address listed below to provide or seek information related to my dental benefits, including oral health news, product developments, service enhancements, and quality surveys. I understand email is not a secure form of communication and there may be inherent risks when submitting sensitive or personal information via email.

Employee Name: _____ **Cell Phone #:** _____ **Landline Phone #:** _____

Email Address: _____ **Employee Signature:** _____ **Date:** _____