DELTA DENTAL

# Subgroup Application Addendum – Delta Dental Plan of New Mexico

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

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.

This addendum is hereby made a part of the [Group Insurance Application] applicable to the employer indicated below, for the addition of a billing subgroup(s) with an Effective

Date of the first day of _____, 20 _____ .

Billing subgroups are subject to approval by Delta Dental of New Mexico. Please use an additional Subgroup Information Page and Application Addendum if more than two subgroups are being requested.

## Part A – Group Identification

| Employer (Group) Name: | Group Number: |
|---|---|

## Part B1 – Subgroup Information

| Employer (Subgroup) Name: | Subgroup Number: | | |
|---|---|---|---|
| Street Address: | City: | State: | Zip: |
| Billing Address (If different than Street Address): | City: | State: | Zip: |
| Employer's Industry: | Federal Tax ID: | SIC/NAICS: | |

| Part B2 – Subgroup Contact | Contact Name | Phone Number | Email Address |
|---|---|---|---|
| Contact Title: | First: Last: | | |

## Part C1 – Subgroup Information

| Employer (Subgroup) Name: | Subgroup Number: | | |
|---|---|---|---|
| Street Address: | City: | State: | Zip: |
| Billing Address (If different than Street Address): | City: | State: | Zip: |
| Employer's Industry | Federal Tax ID: | SIC/NAICS: | |

| Part C2 – Subgroup Contact | Contact Name | Phone Number | Email Address |
|---|---|---|---|
| Contact Title: | First: Last: | | |

## Part D – Employer Agreement

I understand that subgroups are approved for billing convenience only; that the approval of a subgroup(s) does not create a different Premium due date(s) for any subgroup(s) under my primary Group number; and that coverage for my entire Group will be terminated for non-payment if Premium payment for any individual subgroup is not made on a timely basis.

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.

Type/printed name of Group Officer:_____ Title: _____

Executed this _____ day of _____, 20_____.

Authorized Signature (Group Officer) _____