DELTA DENTAL

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

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: ____________________

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:**________________________________