DELTA DENTAL

HOW HEALTH through ORAL WELLNESS

DENTAL ENROLLMENT / CHANGE FORM

Delta Dental Plan of Maine – Delta Dental Plan of New Hampshire – Delta Dental Plan of Vermont
Please send form to: eligibilitydepartment@nedelta.com or Eligibility Fax - (603) 223-1252
Northeast Delta Dental – One Delta Drive – PO Box 2002 – Concord, NH 03302-2002 – 1-800-537-1715 – nedelta.com - (603) 223-1230 Eligibility

Be sure to fill out each section completely. Failure to complete each section in full could delay processing.

1. GROUP INFORMATION - To be completed by Employer

Group Number:	Sublocation:	Division:	Misc. Info:	If Dual Option, Select Plan ☐ Low ☐ High ☐ N/A
Group Name:			Address:	

2. SUBSCRIBER INFORMATION – To be completed by Employee

Date of Hire: (MM-DD-YYYY)	Date of Rehire: (MM-DD-YYYY)	Subscriber Effective Date: (MM-DD-YYYY)	
Social Security No:	Last Name:	First Name:	
Date of Birth:	Sex: ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	
Mailing Address:	City:	State:	Zip:
Email Address:		Phone Number:	

3. ENROLLMENT OR CHANGE REQUEST

Exact Date of Change: (MM-DD-YYYY)

Coverage Level Requested: ☐ Subscriber Only ☐ Subscriber & Spouse ☐ Subscriber & Child ☐ Subscriber & Children ☐ Family

Reason for Change: ☐ Add ☐ Delete

☐ New Hire ☐ Open Enrollment ☐ Marriage ☐ Birth/Adoption ☐ COBRA ☐ Address Change ☐ Loss of Coverage ☐ Employment Change
☐ Name Change:
☐ Transfer from Sublocation:
☐ Other/Explain:

Will this dental coverage replace another Northeast Delta Dental Plan? If yes, provide the Subscriber ID/SSN and Name:

4. DEPENDENT INFORMATION

List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion. If you are enrolling some but not all your eligible dependents, your other dependents must have coverage elsewhere.

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Sex	Relationship to Subscriber	*	Add/Remove	Email for Spouse and/or Dependents over the age of 18
			☐ F ☐ M	☐ Spouse ☐ Domestic Partner ☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	

*Check box if dependent is incapacitated. Legal documentation may be required.

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. **By signing below I hereby accept coverage. This policy provides dental benefits only. Review your policy carefully.**

SUBSCRIBER SIGNATURE (REQUIRED): _____ DATE: _____

Please retain a copy for your records.