

800-537-1715 Corporate • 603-223-1230 Eligibility • 603-223-1252 Eligibility Fax

Delta Dental Plan of New Hampshire, Inc.

DENTAL ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY - IN BLUE OR BLACK INK ONLY

Please send form to: Northeast Delta Dental PO Box 2002 Concord, NH 03302-2002 Web site: www.nedelta.com

1. SUBSCRIBER INFORMATION	- To be completed by En	olan	vee											
LAST NAME (SUBSCRIBER) FIRST NAME			,			SOCIAL SECURITY / I.D. #			SE	DATE OF BIRTH (MM-DD-YYYY	3			
431 NAME (SUBSCRIBER)					OGGIAL GEGORIT			KII I / I.D. #			,			
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MAILING ADDRESS		С	ITY					STATE	ZIP	TELEPHONE NO.				
										()				
MARITAL STATUS SINC	GLE MARRIED/CIV	 /	NION PARTNER					E-MAIL	<u>!</u>		٦			
□ DIVORCED □ WIDOWED														
OTHER														
2. GROUP INFORMATION														
GROUP NAME		6.1	TREET ADDRESS	e ci	TV C	TATE	710	<u> </u>						
GROUP NAME		3'	TREET ADDRESS	5, CI	11,3	IAIE	, ZIF							
GROUP NUMBER SUBLOCATION NUMBER					DIVISION MISC. INFO (i.e. STORE LOC)									
EFFECTIVE DATE (MM-DD-YYYY) EMPLOYEE DATE OF HIRE (MM-DD-YYYY) EMPLOYEE DATE OF REHIRE (MM-DD-YYYY)														
EFFECTIVE DATE (MIM-DD-1111)	FFECTIVE DATE (MM-DD-1111) EMPLOYEE DATE OF HIRE (MM-DD-1111)						EMPLOTEE DATE OF REFIRE (MIMI-DD-TTTT)							
3. REASON FOR ENROLLMENT	CHANCE													
3. REASON FOR ENROLLIMENTA	CHANGE:													
EXACT DATE OF STATUS CHANGE.			(MM-DD-YYYY)	MISCELLANEOUS CHANGE:										
				MISCELLANEOUS CHANGE: □ Name change – Previous name:										
ADD: ☐ New enrollment	DELETE: □ Annual open enrollm	ont		☐ Transfer from sublocation:										
☐ Annual open enrollment	☐ Employment change		spouse/civil union	B Address decree										
□ COBRA Due to:	partner			Other:										
☐ Marriage/Civil union	☐ Full-time to part-time		•	COVERACE LEVEL REQUESTED										
☐ Birth ☐ Other: ☐ Adoption*	☐ Divorce/Termination	of a	civil union	COVERAGE LEVEL REQUESTED ☐ Employee Only ☐ Employee & Spouse/Civil union partner ☐ Employee & Child										
☐ Employment change for spouse/civil	☐ Deceased☐ No longer dependent	t for l	IRS nurnoses	☐ Employee & Children ☐ Family										
union partner	☐ Retirement	1101 .	into purpodos											
☐ Part-time to full-time employment status ☐ Other														
4. DEPENDENT INFORMATION -	List all dependents to b	oe no	ewly enrolled,	or th	nose	dep	ende	ents who are	affected	by an addition or deletion listed				
above in section #3. If you are e	nrolling some but not all	of y	your eligible de	ependents, your other dependents must have coverage elsewhere.										
Last Name			Relationship	 	Date Of Birth			Check if Dependent		E-Mail for Spouse and/or	oil for Spauge and/or			
(If Different)	First Name	М.І.			Day			Under Age 26	De	ependents Over the Age of 14				
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		Т				\Box	П							
					*Che	ck if	dene	ndent is incar	nacitated L	egal documentation may be required	_			
F OTHER CROUP COVERAGE	COORDINATION OF REN	11-1-1	TC)		One	CKII	uepe	indent is inca	Jacitateu. L	egar documentation may be required				
5. OTHER GROUP COVERAGE (COORDINATION OF BEN	IEFI	15)											
Will you, your spouse/civil union partne								•		Yes No				
Will this dental coverage replace anoth	er Northeast Delta Dental Pla	n?	☐ Yes		10	If yes	s to e	either question	n, complete	the following:				
DENTAL INSURANCE COMPANY	POLIC	CYHC	OLDER ID # / SO	CIAL	SECI	JRIT	Y #	EFFECTIVE D	ATE (MM-D	D-YYYY)				
Statements made in this document	are deemed to be represent	tatio	ns and not warra	antie	s. I re	eprese	ent th	nat all informati	on is true an	nd correct to the best of my knowledge.	ī			
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			• •							nrolled and can discontinue our coverag	е			
only during open emoliment, except in	the event of a qualified fairlify	Statu	is change. by sig	iiiig	Delo	WITTE	неву	, accept cover	aye.					
This policy provides dental benefits	only. Review your policy ca	ırefu	lly.											
SIGNATURE (REQUIRED):					DAT	_								
SIGNATURE (REQUIRED):					DAI	E:								