DELTA DENTAL

Delta Dental of Minnesota

DeltaVision®

Enrollment/Update Form

Client Name _____ Dental Client/Subclient # _____ - _____

DeltaVision Client/Subclient (***starts with V***)# _____ - _____

PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):		
Type of Update	☐ **New Enrollment** ☐ **Termination** ☐ **Change/Correction to Information** ☐ **Reinstatement** ☐ **Transfer**	
Transfer From: Client/Subclient # -	Transfer To: Client/Subclient # -	Change is for: ☐ Subscriber ☐ Dependent ☐ Spouse/Domestic Partner
FOR SOLUTIONS DUAL OPTION OR MILLENIUM CHOICE℠ PRODUCT ONLY	Select a Dental Plan Option: ☐ Plan Option I – Delta Dental PPO ☐ Plan Option II – Delta Dental Premier	

SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):				
Subscriber Name (Last)	(First)	(Middle initial)	Gender	
Social Security Number - -	Birth Date (MM/DD/YYYY) / /	Coverage Effective Date (MM/DD/YYYY) / /	Hire Date (MM/DD/YYYY) / /	
Street Address			☐ Check here if this is a new address	
City	State	Zip Code	Status* ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving	

DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):						
Relationship to Employee	Last Name, First Name, M.I. (Include Last Name only if different from Subscriber's)	Gender	Date of Birth (MM/DD/YYYY)	Social Security Number - requested but not required**	Status*	**Type of Coverage (select one or both: Dental/Vision)**
Spouse/ Domestic Partner					☐Legal ☐Surviving	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision

*see reverse side for instructions and explanation of codes **Social security number only requested for dependents with same date of birth

SUBSCRIBER AND CLIENT SIGNATURE – Sign and date this form as verification of your enrollment.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my Employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental/DeltaVision reserves the right to decline any further enrollment changes.

Type of Coverage Waived *(check all that apply):* ☐ Dental ☐ Vision

Employee Signature: _____ **Date:** _____

Client Representative Signature _____ **Date:** _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Plan Enrollment/Update Information - This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

New Enrollment:	Check for first time enrollment for yourself or your dependents.
Termination of Coverage:	Check only if you are terminating Dental or Vision coverage for yourself, your spouse or dependents.
Change/Corrections:	Check if any changes to current coverage are being submitted on the form. When reporting a change or correction, the information that is incorrect or has changed should be listed. Please include both the first and last names of any individuals for whom you are enrolling or submitting a change or correction.
Reinstatement:	Check for reinstatement coverage for yourself or your dependents.
Transfers:	Use the "Transfer From: Client#/Subclient# and Transfer To: Client #/Subclient #" When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

Subscriber Information - This section must be completed for us to process your enrollment changes or corrections to your record. All information should apply to you, the primary subscriber. Please print clearly or type.

Coverage Effective Date: The date that Dental or Vision coverage or changes take effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active:	You are a current/active subscriber.
Retiree:	You are retired and your employer continues to provide you with benefits.
COBRA:	You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Dependent Information – This section must be completed for us to process your enrollment changes or corrections to the record(s) for a spouse, domestic partner or dependent. Please print clearly or type.

Dependent Status Definitions:

Legal:	Your current spouse.
Surviving:	The surviving spouse/domestic partner, or child of a deceased subscriber.
Disabled:	Your permanently disabled child.
Sponsored:	A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's group contract.
Full Time Student:	An individual who is your dependent child according to the U.S. Internal Revenue Code. This Student could include your married or unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Email: eligibility@mydeltadental.com

Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916