



## Dental Enrollment Change Form For Options Blue Members

### Delta Dental Of Minnesota

Use this form for changes only. Do not use this form to cancel coverage. Please print clearly. If information is missing or illegible, this form may be returned and it can delay your enrollment. Send completed application to: Delta Dental of Minnesota ♦ Attn: Enrollment Department ♦ PO Box 330 ♦ Minneapolis MN 55440-0330.

**PART A – SUBSCRIBER INFORMATION** – Complete all areas and indicate if you are providing a new address.

<b>Subscriber's Name:</b>	Last	First	Middle Initial	<b>Social Security Number</b> / /
Day Phone Number	Evening Phone Number	Email Address		<b>Date of Birth</b> / /
<b>Subscriber's Address:</b> <input type="checkbox"/> Check If New Address	Address			
	City	State	Zip Code	
<b>Options Blue Member's XZ Number:</b> Refer to your Medical ID Card to obtain number.				
<b>Options Blue Agent Information:</b>	Agent Name	Agent Phone Number	Agency Code/ Number	

**PART B – CHANGE NAME** - Select one category and provide former and new name.

**Change Subscriber Name**       **Change Dependent Name**  
 Former Name: \_\_\_\_\_  
 New Name: \_\_\_\_\_

**PART C – CHANGE PLAN OPTION** - Select new Plan option. You may only change Plan options at the time of your annual renewal.

**Options Blue Dental:**    **Plan A** (\$100 Deductible/\$1250 Plan Maximum)    **Plan B** (\$250 Deductible/\$1000 Plan Maximum)  
 **Yes, I Elect Orthodontic Coverage**    **No, I Do Not Elect Orthodontic Coverage**

**PART D – FAMILY STATUS CHANGE** - Add or cancel family member(s) coverage.

**Note:** Your benefit elections are intended to remain the same for the entire Coverage Year. You may only change your benefits during the Coverage Year if you experience an eligible Family Status Change. Eligible changes are: change in marital status (divorce, legal separation, marriage), birth, adoption, death, child marries and is no longer eligible, child reaches plan's maximum age, or loss of other insurance coverage.

**Select Add Coverage or Cancel Coverage. Provide the reason and family member information.**

**Add Coverage for One or More Family Members**       **Cancel Coverage for One or More Family Members**  
 Reason for Add: \_\_\_\_\_      Reason for Cancellation: \_\_\_\_\_

Family Member's First Name, Middle Initial, Last Name	Relationship to Subscriber	Gender	Date of Birth Month/Day/Year	Dependent Unmarried?
		M   F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
		M   F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
		M   F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART E – CHANGE PAYMENT METHOD** - Select New Payment Option and Billing Frequency

**A. Direct Withdrawal from Checking Account:**    **Monthly**    **Quarterly**   **Effective Date of Change** \_\_\_\_\_  
 Name on Checking Account: \_\_\_\_\_ Bank Name: \_\_\_\_\_  
 Routing Number: \_\_\_\_\_ Checking Account Number: \_\_\_\_\_  
 Please send a voided check or copy of a voided check with this form.

**B. Credit Card:**    **Quarterly**    **Annual**   **Effective Date of Change** \_\_\_\_\_  
 American Express    Discover    MasterCard    Visa  
 Credit Card Number \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_  
 Name As It Appears On Credit Card \_\_\_\_\_

**C. Check:**    **Quarterly**    **Annual**   **Effective Date of Change** \_\_\_\_\_

**PART F – AUTHORIZATION AND VERIFICATION** – Sign and date as verification of your change request.

I am requesting the changes as indicated above. I certify the information contained in this application is true and complete. The start and cancellation dates of my insurance coverage will be determined by Delta Dental of Minnesota. The start date is generally the first day of the month following receipt of a request. The cancellation date is generally the last day of the month in which the cancellation request is received. If I have selected Payment Method A or B, I authorize Delta Dental to withdraw funds from my checking account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made timely I will no longer be eligible for coverage.

**Subscriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_