



**Individual Plan for  
Blue Cross Blue Shield of Minnesota  
Medicare Supplement/Medicare Select Members  
Enrollment Change Form**

**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>Enrollee's Name:</b>	Last	First	Middle Initial	<b>Social Security Number</b> / /
Day Phone Number	Evening Phone Number	e-mail Address		<b>Date of Birth</b> / /
<b>Enrollee's Address:</b> <input type="checkbox"/> <b>Check If New Address</b>	Address			
	City	State	ZIP Code	
<b>Blue Cross / Blue Plus Member ID:</b>		<b>Group Number</b>		

**PART B – CHANGE NAME**

Former Name: \_\_\_\_\_  
New Name: \_\_\_\_\_

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

**A. Direct Withdrawal from Checking Account:**  **Monthly**  **Quarterly**  **Annual**  
**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 D – 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.

**Enrollee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR AGENT USE ONLY**

Agent Name:	Agent Phone:
Agency Code:	Agent's Number: