



**Individual Dental Plan for
Blue Cross and 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.

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

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: