DELTA DENTAL®

Delta Dental Individual and Family - Singular for AAA 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.

Subscriber's Name: **Primary AAA Mpls Member**	Last	First	Middle Initial	**Social Security Number** / /
Day Phone Number	Evening Phone Number	Email Address		**Date of Birth** / /
Primary AAA Mpls Membership Number:				
Subscriber's Address:	Address			
☐ **Check If New Address**	City	State	Zip Code	

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. **Note:** You may only change options at the time of your annual renewal

☐ **Plan 1** ($25 Deductible / $1000 Plan Maximum) ☐ **Plan 2** ($25 Deductible / $1500 Plan Maximum)

PART D – FAMILY STATUS CHANGE - Select Add Coverage or Cancel Coverage. Provide the reason and family member information.

Note: Your benefit elections are intended to remain the same for the entire Coverage Year regardless of a change in your AAA membership status. When adding or canceling coverage due to a family status change, you must maintain the same membership category as your AAA membership. If you have Primary AAA membership only, you may only enroll yourself. If you have Primary AAA plus an Associate membership, you may enroll yourself, one or more Associate members and dependent children to age 23. 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, and marriage), birth, adoption, death, child reaches plan's maximum age of 23, and loss of other insurance coverage.

☐ **Add Coverage for One or More Family Members** ☐ **Cancel Coverage for One or More Family Members**
Reason for Add: _____ Reason for Cancellation: _____

Relationship to Primary AAA Mpls Member	**First Name, Middle Initial, Last Name** (Include Last Name Only if Different From Subscriber's)	**Gender**		**Date of Birth** Month/Day/Year
Spouse/Domestic Partner		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

PART E – CHANGE PAYMENT OPTION - 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 ____/____ Security Code _____
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 Option A or B, I authorize Delta Dental of Minnesota 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:**