



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: Last First Middle Initial Social Security Number
Primary AAA Mpls Member
Day Phone Number Evening Phone Number Email Address Date of Birth
Primary AAA Mpls Membership Number:
Subscriber's Address: 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.

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

Table with columns: Relationship to Primary AAA Mpls Member, First Name, Middle Initial, Last Name, Gender, Date of Birth

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

A. Direct Withdrawal from Checking Account: Monthly Quarterly Effective Date of Change
B. Credit Card: Quarterly Annual Effective Date of Change
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.

Subscriber Signature: Date: