



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 / /
Day Phone Number Evening Phone Number Email Address Date of Birth / /
Subscriber's Address: Address
City State Zip Code
Check If New Address

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 Plan options at your annual renewal.

Plan 1 (\$50 Deductible / \$750 Plan Maximum) Plan 2 (\$25 Deductible / \$1500 Plan Maximum)

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 / / Yes No
M F / / Yes No
M F / / Yes No
M F / / Yes 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: