DELTA DENTAL

Delta Dental of Minnesota

Delta Dental for Individuals & Family - Healthcare Reform Certified Plans
Enrollment Change Form

Use this form for changes only. Please print clearly. If information is missing or illegible, this form may be returned and it can delay your request. Send completed application to: Delta Dental of Minnesota ♦ Attn: Enrollment Department ♦ PO Box 74008400 ♦ Chicago, IL 60674-8400

SUBSCRIBER INFORMATION – Complete all areas and indicate if you are providing a new address.

Subscriber's Name:	Last	First	Middle Initial	**Social Security Number** / / (requested but not required)
Day Phone Number	Evening Phone Number	Email Address		**Date of Birth** / /
Subscriber's Address:	Address			
☐ **Check If New Address**	City	State	Zip Code	

CHANGE NAME - Select one category and provide former and new name.

☐ **Change Subscriber Name** ☐ **Change Dependent Name**

Former Name: _____

New Name: _____

CHANGE PLAN OPTION - Select new Plan option. **Note:** You may only change Plan options at your annual renewal.

Adult Dental ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan G

Pediatric Dental: Must select one ☐ Plan A ☐ Plan B

FAMILY STATUS CHANGE / CANCEL 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. If coverage is cancelled, you may not be able to re-enroll until the following January.

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

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

☐ **Cancel All Coverage as of** :_____(must be end of month) Reason for Cancellation: _____

Relationship to Subscriber	**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	/ /

CHANGE PAYMENT METHOD - Select New Payment Option and Billing Frequency

☐ **A. Direct Withdrawal from Checking Account:** ☐ **Monthly** **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:** ☐ **Monthly** **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:** ☐ **Monthly** **Effective Date of Change** _____

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:**

- **NOTE:** This document is also available in alternative formats upon request and at no cost to persons with disabilities. To receive this document in a language other than English, please contact the numbers below

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card

If you believe that Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Minnesota, Attn: Complaints, Appeals, and Grievances, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-643-3582 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-643-3582 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-643-3582 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-643-3582 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-643-3582（TTY：711）. (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-643-3582 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-643-3582 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-643-3582 (መስማት ለተሳናቸው: 711). (Amharic)

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤနှ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စုၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-855-643-3582 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-643-3582 (TTY: 711). (German)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-643-3582) رقم .(711 :والبكم الصمم (Arabic)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-643-3582 (ATS : 711). (French)

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PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-643-3582 (TTY: 711). (Tagalog)

ئاگاداری: ئەگەر هەر زمانی کوردی قسە دەکەیت، خزمەتگوزارییەکانی یارمەتی زمان، بەخۆڕایی، بە تۆ (Kurdish) هەردەستە. پەیوەندی بە 1-855-643-3582 (TTY: 711) بکە.

توجه: اگر هب زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. بگیرید با 1-855-643-3582 (TTY: 711) تماس (Persian / Farsi)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-643-3582 （TY:711）まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-643-3582 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-643-3582 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-643-3582 (TTY: 711). (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षण: यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, नि:शुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-855-643-3582 (TTY: 711) मा कल गर्नुहोस्। (Nepali)