Delta Dental of Minnesota

# Delta Dental Group - Healthcare Reform Certified Plans
## Membership Enrollment Form

**PART A – EMPLOYEE INFORMATION** – Employee complete Parts A through E and return form to benefit administrator.

| **Employee's Name:** Last | First | Middle Initial | **Social Security Number** / / (Requested by not required) |
|---|---|---|---|
| **Gender:** Male Female | **Marital Status:** Single Married Widowed Divorced Legally Separated | | **Date of Birth** (Month-Day-Year) / / |
| **Employee's Address:** Address | | Day Phone Number | Evening Phone Number |
| City | State | Zip Code | |

**PART B – ENROLLMENT INFORMATION - Select Coverage Type (Check One Box Only):**

| | | |
|---|---|---|
| Employee Only | Employee and Dependent Child(ren) | Dependent Child(ren) Only – under age 19 |
| Employee and Spouse or Domestic Partner | Family | No Coverage |

**PART C – DEPENDENT INFORMATION**

| Relationship to Employee | First Name, Middle Initial, Last Name (Include last name only if different from employee's) | Gender | | Date of Birth (mm/dd/yyyy) |
|---|---|---|---|---|
| Spouse Domestic Partner | | M | F | / / |
| Dependent Child | | M | F | / / |
| Dependent Child | | M | F | / / |
| Dependent Child | | M | F | / / |

**Part D – PLAN SELECTION** – Complete this section with the information provided to you by your benefit administrator.

**Select Plan:** Select one Adult Dental Plan for adult(s) and/or dependent child(ren) age 19+ being enrolled. Select one Pediatric Dental Plan for dependent child(ren) under age 19 being enrolled.

**Adult Dental** Bronze Silver Gold Platinum

**Pediatric Dental** Low High

**PART E – EMPLOYEE SIGNATURE** – Sign and date form as verification of your enrollment.

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

**Employee Signature:** **Date:**

**PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER**

**New Group**
Hire Date:________ /________ /________
Prior Coverage Start Date (if applicable):________ ________/________
Coverage Effective Date________/________/________

**Rehire** Date Lay Off Began:________/________/________
Date Rehired:________/________/________

**Return from Leave of Absence**
Date Leave Began:________/________/________
Date Returned to Work:________/________/________

**Existing Delta Dental Group**
Hire Date :________ /________ /________
Prior Coverage Start Date (if applicable):________/________/________
Coverage Effective Date: /________ /________ /________

**Employee Change Part Time to Full Time**
Date of Status Change:________ /________ /________
Effective Date:________/________/________

**New Hire** – Apply Probationary Period (if applicable) to determine Effective Date
Hire Date:________/________/________
Effective Date:________/________/________

**Open Enrollment**
Effective Date:
________/________/________

**Qualifying Event or Special Enrollment Period**
Qualifying Event Reason:________________
Hire Date:________/________/________
Event Date:________/________/________
Effective Date:________/________/________

**Group Name:** **Group & Subgroup Numbers:** ---

**Group Representative's Signature:** **Date:** **Phone Number: ( )**

# Employer Instructions

- ReviewParts A, B, C, D, E, and F to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Delta Dental of Minnesota generally completes enrollment requests within five business days of receipt.

**Complete Part F - Group Enrollment Information**

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer to Delta Dental and submitting initial employee enrollment. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies. Note: For a New Group enrolling a Direct Billed COBRA participant, write Direct Bill in the New Group section. If information is not provided, participant will not be enrolled and billed properly.
- **Existing Delta Dental Group** – Enrolling additional employees from an acquisition/merger who were not previously offered/ enrolled in you Delta Dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **New Hire** – Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- **Open Enrollment** – An employee is enrolling during group's open enrollment period.
- **Rehire** – A former employee was rehired.
- **Return From Leave of Absence** – An employee is returning from leave of absence.
- **Employee Change Part Time to Full Time** – The employee's employment status changed and the employee is now eligible for dental benefits.
- **Qualifying Event or Special Enrollment Period** – If an employee waives coverage, he/she can only enroll at a later date if the group contract includes an Open Enrollment period or if the employee had an eligible qualifying event such as: marriage, divorce, birth, adoption, which allows the employee to enroll in coverage outside of any open enrollment period.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

**Send Completed Forms To:**
Delta Dental of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis, MN 55440-0330

NONDISCRIMINATION: 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.

Disability:
This document is also available in alternative formats upon request and at no cost to persons with disabilities. Delta Dental provides free aids and services to people with disabilities to communicate effectively with us. Please call the number on the back of your ID card if you desire such aids or services.

Foreign language:
Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-553-9536 (TTY: 711).

Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1- 800-553-9536 (TTY: 711).

Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-553-9536 (TTY: 711).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-553-9536 (TTY: 711).

Chinese 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 1-800-553-9536（TTY：711）。

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-553-9536 (телетайп: 711).

Laotian ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-553-9536 (TTY: 711).

Amharic ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-553-9536 (መስማት ለተሳናቸው: 711).

Karen ymol.ymo;= erh>uwdRAunDAusdmtCdAusdmtw>rRpXRvXAwvXmbl.vXmphRAeDwrHRb.ohM. vDRIAud; 1-800-553-9536 (TTY: 711).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-553-9536 (TTY: 711).

Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-553-9536 (TTY: 711)។

Arabic ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-553-9536 (رقم هاتف الصم والبكم: 711).

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-553-9536 (ATS : 711).

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-553-9536 (TTY: 711)번으로 전화해 주십시오.

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-553-9536 (TTY: 711).

**How to Get Language Assistance**

*Delta Dental is committed to communicating with our members about their dental plan, no matter what their language is. Delta Dental employs a language line interpretation service for use by our customer service call center. Simply call the customer service phone number on the back of your identification card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.*