DELTA DENTAL®

Delta Dental of Minnesota

Membership Maintenance Form

PART A - EMPLOYEE INFORMATION

Employee's Name:	Last	First	Middle Initial	**Social Security Number** / /
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
☐ **Check If New Address**	City	State	Zip Code	

PART B – CHANGE REQUEST - Check all categories that apply and provide information requested by category.

☐ **Name Change**
Former Name:_____
New Name: _____

☐ **Terminate Employee and All Dependent Coverage**
Date of Termination: _____/_____/_____
Date Coverage Ends: _____/_____/_____

☐ **Change Employee Group/Subgroup** (Move individual to different subgroup, including to COBRA subgroup)
From:_____ To:_____
Effective Date of Change: _____/_____/_____

☐ **Millennium Choice Groups Change Plan Option at Open Enrollment**
☐Plan Option I - Delta Dental PPO ☐ Plan Option II - Delta Dental Premier

☐ **For DeltaCare Groups Change Clinic Code to:** _____
Obtain Clinic Code from DeltaCare Provider Directory

☐ **Enroll in Voluntary Discount Orthodontic Program**

☐ **Change Coverage Type, Add or Drop Dependent Due to Qualifying Event –** List Qualifying Event Code next to correct Coverage Type/Change Request Category. Complete Part C if Adding or Dropping Dependent(s). **Qualifying Event Code**: **A** – Adoption **B** – Birth **D** – Divorce/Legal Separation **E** – Death **L** – Loss of Coverage **M** – Marriage **O –** Open Enrollment **S –** Dependent No Longer Eligible

Qualifying Event Code	Coverage Type / Change Request Category	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /
	Add or Drop Dependent - No Coverage Type Change	/ /	/ /

PART C – DEPENDENT INFORMATION – Adding or dropping dependents may require a Coverage Type change in Part B.

Add	Drop	Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
		Spouse		M	F	/ /				
		Dependent Child		M	F	/ /	Y	N	Y	N
		Dependent Child		M	F	/ /	Y	N	Y	N

PART D – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment change.

☐ I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated below and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

Employee Signature: **Date:**

PART E – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits Employer Note: May require subgroup change.

Qualifying Event Number:
1 Employee Termination or Reduction of Work Hours
2 Employee Death
3 Employee Total Disability
4 Divorce or Legal Separation
5 Employee Eligible For Medicare
6 Dependent No Longer Eligible

Coverage Continuation Applies To:	Event Number	Date of Qualifying Event	Social Security Number
☐ Employee & All Dependents Currently Enrolled		/ /	
☐ Employee Only		/ /	
☐ Spouse Only		/ /	- -
☐ Dependent(s) Only – List Names in Part C		/ /	- -
☐ Employee & Spouse		/ /	
☐ Employee & Dependent Child(ren)–List Names in Part C		/ /	

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

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

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