DELTA DENTAL®
Delta Dental Plan of Minnesota

Dental Flex Enrollment Form

www.deltadentalmn.org

INSTRUCTIONS PROVIDED ON NEXT PAGE

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		Home Phone Number ( )	Work Phone Number ( )
City	State	Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):

- ☐ Employee only*
- ☐ Employee and Spouse
- ☐ Employee and Dependent Child(ren)
- ☐ Family
- ☐ No Coverage*

*** If waiving coverage for employee and/or any eligible family members, you must complete Part D.**

Complete If Your Employer Offers The Voluntary Orthodontic Program

☐ I Elect ☐ I Do Not Elect to Participate in the Voluntary Discount Orthodontic Program

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 Month/Day/Year	Over Age 19 and Full-Time Student
Spouse		M	F	/ /	
Child		M	F	/ /	☐ Yes ☐ No
Child		M	F	/ /	☐ Yes ☐ No
Child		M	F	/ /	☐ Yes ☐ No

PART D – EMPLOYEE SIGNATURE – Select One

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions where applicable. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages.

Employee Signature: **Date:**

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

☐ **New Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Dental Flex Coverage Effective Date: _____/_____/_____

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

☐ **Rehire**
Date Lay Off Began: _____/_____/_____
Date Rehired: _____/_____/_____

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

☐ **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: _____/_____/_____

☐ **Loss of Coverage** – Employee and/or Dependent
Hire Date: _____/_____/_____
Date of Loss: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Previously Waived Coverage**
Qualifying Event Reason: _____
Hire Date: _____/_____/_____
Event Date: _____/_____/_____
Effective Date: _____/_____/_____

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

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

Instructions for Completion of Dental Flex Enrollment Form

Important Notes:

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format.
- Before submitting, review to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt by Delta Dental Plan of Minnesota.

Employee – Complete Parts: A, B, C, D

Part A: Employee Information - Complete all sections.

Part B: Enrollment Information

Select Coverage Type

- Select one category that describes the eligible dependents you want covered under your dental plan.
- If you select *No Coverage,* you and your eligible dependents will not be enrolled and coverage is waived. This may limit your ability to enroll in the future. If this option is selected, you must also waive coverage in Part D.

Voluntary Discount Orthodontic Program – Must Complete if Group Offers Program

- To enroll for this benefit select *Elect* to participate.
- Select *Do Not Elect* if you do not want to participate.

Part C: Dependent Information – Complete Only if Enrolling Dependents

- Complete each section for each eligible dependent being enrolled.
- If enrolling more than four dependents, attach a list of additional dependent information in the same format.

Part D: Employee Signature

- Select one box of: *I waive* or *I am enrolling*.
- Please read, sign and date the form as verification of your selection.
- Return completed form to your benefit administrator.

Employer Complete Part: E - Group Enrollment Information

- Review sections completed by employee to assure information provided 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).
- 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 all dates:
    - Hire Date – date employee was employed by group
    - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Date does not apply if group did not previously have a qualified dental plan. When applicable, provide date employee enrolled in group's prior dental plan.
- **Existing Delta Dental Group** – Existing Delta Dental customer changing benefits to Dental Flex product and submitting employee enrollment.
    - Hire Date – date employee was employed by group
    - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Date does not apply if group did not previously have a qualified dental plan. When applicable, provide date employee enrolled in group's prior dental plan
- **New Hire** – Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was laid off and is being rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Previously Waived Coverage** – Enrolled employee had eligible family status change such as: marriage, divorce, birth, adoption, which allows dependents to be added.
- **Employee Status Change** – Employee's employment status changed and employee is now eligible for dental benefits.
- **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 Plan of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis MN 55440-0330