



Delta Dental of Minnesota

Delta Dental of Minnesota Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A through E. Sign Part F or G as appropriate. Return form to your benefit administrator.

Employee's Name:		Last		First		Middle Initial		Social Security Number / /	
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Legally Separated <input type="checkbox"/>	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 – Who Is Being Enrolled – Check One Box Only * If waiving coverage for employee and/or eligible family members, complete Part F.		Complete If Your Employer Offers The Voluntary Orthodontic Program	
<input type="checkbox"/> Employee only*	<input type="checkbox"/> Family	<input type="checkbox"/> I Elect <input type="checkbox"/> I Do Not Elect	
<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> No Coverage*	to Participate in the Voluntary Discount Orthodontic Program	
<input type="checkbox"/> Employee and Dependent Child(ren)			

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	Full Time Student?		Unmarried?	
Spouse/Domestic Partner		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

PART D – FOR MILLENNIUM CHOICESM GROUPS ONLY

Select a Plan Option: Plan Option I - Delta Dental PPO
 Plan Option II - Delta Dental Premier

PART E – FOR DeltaCare GROUPS ONLY

Obtain Clinic Code from DeltaCare Provider Directory.

Clinic Code: _____
Please Note: Dental benefits are ONLY available when a clinic is chosen.

PART F – OTHER INSURANCE COVERAGE

 – Complete only if employee and/or eligible dependents are not being enrolled.

Do you (the employee) have other dental coverage? Yes No Do your dependents have other dental coverage? Yes No

Name of Carrier: _____ Policy/Identification Number: _____

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.

Employee Signature: _____ **Date:** _____

PART G – 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 knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: _____ **Date:** _____

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

<input type="checkbox"/> New Group		<input type="checkbox"/> Rehire Date Lay Off Began: _____/_____/_____ Date Rehired: _____/_____/_____	
Hire Date: _____/_____/_____		<input type="checkbox"/> Return from Leave of Absence	
Prior Coverage Start Date (if applicable): _____/_____/_____		Date Leave Began: _____/_____/_____	
Coverage Effective Date: _____/_____/_____		Date Returned to Work: _____/_____/_____	
<input type="checkbox"/> Existing Delta Dental Group		<input type="checkbox"/> Employee Change Part Time to Full Time	
Hire Date: _____/_____/_____		Date of Status Change: _____/_____/_____	
Prior Coverage Start Date (if applicable): _____/_____/_____		Effective Date: _____/_____/_____	
Coverage Effective Date: _____/_____/_____		<input type="checkbox"/> Qualifying Event or Special Enrollment Period	
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Effective Date		Qualifying Event Reason: _____	
Hire Date: _____/_____/_____		Hire Date: _____/_____/_____	
Effective Date: _____/_____/_____		Event Date: _____/_____/_____	
<input type="checkbox"/> Open Enrollment		Effective Date: _____/_____/_____	
Effective Date: _____/_____/_____			
Group Name: _____		Group & Subgroup Numbers: _____	
Group Representative's Signature: _____		Date: _____ Phone Number: () _____	

Employer Instructions

- Review Parts A, B, C, D, E, F and G 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 H - 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

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 1-800-553-9536. (Spanish)

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. (Hmong)

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄ່າມື້ພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-553-9536. (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-553-9536. (Amharic)

ymol.ymo;= erh>uwdRAunDAusdmtCdAusdmtw>rRpXRvXAwwXmbl.vXmphRAeDwrHRb.ohM. vDRIAud; 1-800-553-9536. (Karen)

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

مقرب لصتا. ن اجم اب كل رفاوتت ةىوغلل ادعاسملا تامدخ نإف، ةغلل ركذا تددحتت تنك اذا: ةظوح لم 9536) مقر . (Arabic)

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

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-553-9536

번으로 전화해 주십시오. (Korean)

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. (Tagalog)

ۆت ۆب، یی ۆر ۆخ هب، ن ۆم ۆت هب ۆر ای ۆن اک هب ۆر ۆگت هب ۆم ۆخ، ت ۆی هب ۆم ۆس هۆق ۆد رۆک ۆن ۆم ۆب هب ر هگ هب: ۆر اداگائ
پ هب 1-800-553-9536 هب. هتس هدر هب (Kurdish)

دیری گب. امش ی ۆر ب ن اگی ۆر ت ر و ص ب ۆن ابز ت ال ی هتس، د ۆن ک ۆم و گت ف گ ۆس ر ا ف ن ابز هب ر گ ا: هج و ت
ف ۆم دش اب. اب 1-800-553-9536 س ام ت (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。1-800-553-9536 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 1-800-553-9536. (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-553-9536. (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-553-9536. (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-553-9536. (Cambodian/Khmer)

ध्यानाकर्षणः यदि तपाईं [नेपाली] बोलनुहुन्छ भने, निःशुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-800-553-9536 मा कल गर्नुहोस्। (Nepali)