

**DENTAL ENROLLMENT / CHANGE FORM**

PLEASE TYPE OR PRINT LEGIBLY – IN BLUE OR BLACK INK ONLY

Please send form to:
Northeast Delta Dental
PO Box 2002
Concord, NH 03302-2002
Web site: www.nedelta.com**1. SUBSCRIBER INFORMATION - To be completed by Employee**

LAST NAME (SUBSCRIBER)		FIRST NAME		SOCIAL SECURITY / I.D. #		SEX <input type="checkbox"/> M <input type="checkbox"/> F		DATE OF BIRTH (MM-DD-YYYY) — —			
MAILING ADDRESS				CITY		STATE		ZIP		TELEPHONE NO. ()	
MARITAL STATUS						E-MAIL					
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED / CIVIL UNION PARTNER											
<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED											
<input type="checkbox"/> OTHER _____											

2. GROUP INFORMATION

GROUP NAME				STREET ADDRESS, CITY, STATE, ZIP							
GROUP NUMBER		SUBLOCATION NUMBER			DIVISION				MISC. INFO (i.e. STORE LOC)		
EFFECTIVE DATE (MM-DD-YYYY) — —		EMPLOYEE DATE OF HIRE (MM-DD-YYYY) — —			EMPLOYEE DATE OF REHIRE (MM-DD-YYYY) — —						

3. REASON FOR ENROLLMENT/CHANGE:

EXACT DATE OF STATUS CHANGE _____ (MM-DD-YYYY)				MISCELLANEOUS CHANGE:							
ADD:				DELETE:				<input type="checkbox"/> Name change – Previous name: _____			
<input type="checkbox"/> New enrollment				<input type="checkbox"/> Annual open enrollment				<input type="checkbox"/> Transfer from sublocation: _____			
<input type="checkbox"/> Annual open enrollment				<input type="checkbox"/> Employment change for spouse/civil union partner				<input type="checkbox"/> Address change			
<input type="checkbox"/> COBRA Due to:				<input type="checkbox"/> Full-time to part-time employment status				<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Marriage/Civil union				<input type="checkbox"/> Divorce/Termination of a civil union				COVERAGE LEVEL REQUESTED			
<input type="checkbox"/> Birth <input type="checkbox"/> Other:				<input type="checkbox"/> Deceased				<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse/Civil union partner <input type="checkbox"/> Employee & Child			
<input type="checkbox"/> Adoption*				<input type="checkbox"/> No longer dependent for IRS purposes				<input type="checkbox"/> Employee & Children <input type="checkbox"/> Family			
<input type="checkbox"/> Employment change for spouse/civil union partner				<input type="checkbox"/> Retirement							
<input type="checkbox"/> Part-time to full-time employment status				<input type="checkbox"/> Other _____							

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

Last Name (if Different)	First Name	M.I.	Relationship To Subscriber	Date Of Birth				Check if Dependent Under Age 26	E-Mail for Spouse and/or Dependents Over the Age of 14
				Mo	Day	Yr	*		

*Check if dependent is incapacitated. Legal documentation may be required.

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse/civil union partner, or any dependent be covered under any other group plan while this policy is in effect? Yes No

Will this dental coverage replace another Northeast Delta Dental Plan? Yes No *If yes to either question, complete the following:*

DENTAL INSURANCE COMPANY	POLICYHOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY) — —
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Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. **By signing below I hereby accept coverage.**

This policy provides dental benefits only. Review your policy carefully.

SIGNATURE (REQUIRED): _____ DATE: _____