DELTA DENTAL

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 ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address					Day Phone Number 218.591.9040		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**
☐ Employee only* ☐ Family ☐ Employee and Spouse ☐ No Coverage* ☐ Employee and Dependent Child(ren)	☐ 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	**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 CHOICE℠ 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

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

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

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

☐ **Open Enrollment**
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: _____/_____/_____

☐ **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: ( )**

◆ Send Original Copy to Delta Dental + Retain Copy For Your Records +

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 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. (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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-553-9536. (Laotian)

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

ymol.ymo;= erh>uwdRAunDAusdmtCdAusdmtw>rRpXRvXAwvXmbl.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)

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

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ
پ بە 1- 800-553-9536 بکە. .بەردەستە (Kurdish)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. بگیرید
ف می باشد. با 1-800-553-9536 تماس(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)

ध्यानाकर्षण: यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, नि:शुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-800-553-9536 मा कल गर्नुहोस्। (Nepali)