DELTA DENTAL

Delta Dental of Minnesota

Delta Dental of Minnesota
Membership Maintenance Form

PART A - EMPLOYEE INFORMATION - Employee complete Part A through Part E, as appropriate.

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: ☐ Check If New Address	Address					Day Phone Number		Evening Phone Number	
	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:_____/_____/_____

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

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

☐ **Enroll or Disenroll from the 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 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	Effective Date of Coverage	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

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

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

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

Instructions for Completion of Membership Maintenance Form

Important Notes:

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

Part A: Employee Information - Complete all sections.

Part B: Change Request

- **Name Change** – Provide name as previously reported and new name.
- **Terminate Employee and All Dependent Coverage** – Only use this section if the employee and all dependent coverage is being terminated.
- **Millennium Choice Groups Change Plan Option at Open Enrollment** – Use for employees currently enrolled in Millennium Choice to select new network during group's Open Enrollment.
- **DeltaCare Groups Change Clinic Code** – List new clinic code found in DeltaCare Provider Directory.
- **Enroll or Disenroll from Voluntary Discount Orthodontic Program –** Applies only to groups offering this program.
- **Change Coverage Type, Add or Drop Dependent Due to Qualifying Event** – Complete this section to change *Coverage Type* and/or to add or drop dependent's coverage. Provide detailed information for each dependent being added or dropped in Part C.

Part C: Dependent Information

- List and complete all sections for each dependent to be added or dropped, as requested in Parts B and E.
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

Part D: Employee Signature

- Please read and sign form as verification of your change request.
- Return completed form to your benefit administrator.

Part E: COBRA – Complete this section only if an individual has selected continuation of coverage under COBRA.

- Select *to whom the Coverage Continuation applies*, the appropriate *Qualifying Event Number, Date of Qualifying Event* and *Effective Date of Coverage.*
- If employee is not enrolling for COBRA, provide Social Security Number of individual who is being enrolled. If only children are being enrolled, provide the social security number of the youngest child
- If group has a separate COBRA subgroup, it must be provided in Part F.

Part F: Group Information – Completed By Employer

- **Change Employee Group/Subgroup** – Move employee from one group/subgroup to another for benefit, reporting or COBRA purposes.
- **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 ኣማርኛ 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)

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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)

ئاگادارى: ئەگەر هب زمانى كوردى قسە دەكەيت، خزمەتگوزارىيەكانى يارمەتى زمان، بەخۆڕايى، بۆ تۆ (Kurdish)

پ هب 1-800-553-9536 هکب. .هتسەدرهب
توجه: اگر هب زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان بارای شما فراهم می گردد. تماس 1-800-553-9536 اب. اب دشاب می ف(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)