

Delta Dental of Minnesota

Delta Dental of Minnesota Membership Maintenance Form

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

Mama	Employee's Last					First	First				Initial	Social Security Number					
Name:						TO O SOMETRO			M-SUN GLASSION					/			
Gender	r:	Male	Female	Marital Status:	Single	Married	Widowe	ed Divorced	Legally Separ	ated		Date of B	irth (M	onth-D	ay-Year)		
Employ		<u> </u>	Address	Status.						С	Day Phone Nun	nber	E	vening Pho	one Number		
Chec	(T) (1)		City					State				Zip Code					
New Ac																	
PART B	- CH	ANGE	REQUEST - C	heck all cate	gories that	apply and p		e information		_							
☐ Name Change ☐ Terminate Employee and All Dependent Coverage																	
Forme		8					Date of Termination:/										
New N			Choice Group	s Change Pla	an Option a	at Open Enr		Date Coverag	e Enas:		/						
☐ PI	lan Op	ption I	- Delta Denta	I PPO P	lan Option												
			Code from De			ory											
☐ En	roll or	r Diser	nroll from the	Voluntary	Discount O	rthodontic I	Progra	am									
Reques	t Cate	egory.	Complete Pa	rt C if Adding	or Droppi	ng Depende	ent(s).	Event – List Q Qualifying Ev e O – Open E	ent Code: A	- A	doption B	- Birth D			/Change		
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Employee & Dependent Chile					nild(ren)	d(ren)								<u>/</u>			
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				or Drop De						/	/				/		
PART C	- DEI	PENDE	ENT INFORM	ATION - Add	ling or drop	ping depen	dents	may require	a Coverage	Тур		272 27	_				
			ationship	2000000	•	iddle Initial,					Date of			Time			
Add Di	rop		mployee	(Include La	ast Name On	ly if Different	From	Employee's)	Gend		Month/D	ay/Year	Stud	lent?	Unmar	ried?	
		5	Spouse						M	F	/	/					
									M	F	/	/	Y	N	Y	N	
		Deper	ndent Child										Ť	_	+	_	
	_		ndent Child ndent Child						М	F	/	/	Y	N	Υ	N	
PART D		Deper	ndent Child	RE – Sign and	d date form	as verificat	ion of	your enrollm		_	/	/		N	Y	N	
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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 <u>not</u> 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-553-9536. (Laotian)

ጣስታወሻ: የሚናንሩት ቋንቋ ኣጣርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊ*ያግ*ዝዎት ተዘ*ጋ*ጀተዋል፡ 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)

المحقوط مقرب لصتا بن الجملاب كل رفاوت قي غللا قدعاسملا تامدخ ناف ، فغللا ركذا شدحت تنك اذا فظوحلم (Arabic) . مقر

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

aa: aaaa aaaaa aa, aa aa aaaa aaa aaaa	□ □□□□. 1-800-553-9536
□ □ □ □ □ □ □ □. (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)

(Kurdish) وَت وَب ،ىىارِ وَخهب ،نامز ىتهمراى ىناكهى ازوگت همزخ ،تى هكەد هسىھق ىدروك ىنامز هب ر هگەئ :يراداگائ

پ هب 9536-553-980 -1 هکب. هتس در هب دیری گب. امش یاربن اگیار تروصب ین ابز تالی هست ،دینک یم وگتفگ یسر اف ن ابز هب رگا : هجوت

ف ىم دشاب .اب 9536-553-1-800 سامت(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 [ភាសខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-553-9536. (Cambodian/Khmer)

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