



Delta Dental PPO plus Premier – Pathfinder Plan
Membership Enrollment Form

Delta Dental of Minnesota

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to 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 City State Zip Code Day Phone Number Evening Phone Number

PART B – ENROLLMENT INFORMATION

Select Coverage Type – Who Is Being Enrolled – Check One Box Only
Employee only* Family
Employee and Spouse No Coverage * If waiving coverage for employee and/or any eligible family members, complete Part D.
Employee and Dependent Child(ren)

PART C – DEPENDENT INFORMATION

Table with columns: 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?. Rows include Spouse, Domestic Partner, and three Dependent Child entries.

PART D – OTHER INSURANCE COVERAGE – Complete 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 E – 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 F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

New Group Existing Delta Dental Group New Hire – Apply Probationary Period (if applicable) to determine Effective Date Open Enrollment Previously Waived Coverage or Loss of Coverage
Hire Date: Prior Coverage Start Date (if applicable): Coverage 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 Reason: Hire Date: Event Date: Effective Date: