DELTA DENTAL®

800-537-1715 Corporate • 603-223-1230 Eligibility • 603-223-1252 Eligibility Fax

Delta Dental Plan of Vermont

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. #	GENDER	DATE OF BIRTH (MM-DD-YYYY)
			M F	— —

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS SINGLE MARRIED / CIVIL UNION PARTNER DIVORCED WIDOWED OTHER _____

E-MAIL

2. GROUP INFORMATION

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP
FCSU -	28 Catherine Street, St. Albans, VT 05478

GROUP NUMBER	SUBLOCATION NUMBER	DIVISION	MISC. INFO (i.e. STORE LOC)
7777			

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)

ADD:
- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ COBRA Due to:
- ☐ Marriage/Civil union
- ☐ Birth ☐ Other: _____
- ☐ Adoption*
- ☐ Employment change for spouse/civil union partner
- ☐ Part-time to full-time employment status

DELETE:
- ☐ Annual open enrollment
- ☐ Employment change for spouse/civil union partner
- ☐ Full-time to part-time employement status
- ☐ Divorce/Termination of a civil union
- ☐ Deceased
- ☐ No longer dependent for IRS purposes
- ☐ Retirement
- ☐ Other _____

MISCELLANEOUS CHANGE:

Name change – Previous name: _____

Transfer from sublocation: _____

Address change

Other: _____

COVERAGE LEVEL REQUESTED

☐ Employee Only ☐ Employee & Spouse/Civil union partner ☐ Employee & Child ☐ Employee & Children ☐ Family

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 Mo Day Yr	Check if Dependent under age 26	Check if Dependent is Incapacitated

[1]**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)
		— —

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 policiy provides dental benefits only. Review your policy carefully.

SIGNATURE **(REQUIRED)**: _____ DATE: _____

Please retain a copy for your records