DELTA DENTAL®
Delta Dental Plan of Minnesota

Membership Maintenance Form

Delta Dental Plan of Minnesota
Attn: Eligibility Department
P.O. Box 330
Minneapolis, MN 55440-0330
(651) 406-5927 or (800) 928-5713
FAX (651) 406-5935 or (800) 821-5946

COMPLETE ALL APPLICABLE PARTS OF THIS FORM (Please Print)

PART A - EMPLOYEE INFORMATION

Employee's Name: Last | First | Middle Initial

Social Security Number: ___ - ___ - ___

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Birthdate: ___ - ___ - ___

Employee's Address:
☐ Check if new address

Address | Home Phone Number ( ) | Work Phone Number ( )

City | State | Zip Code | County

PART B - CHANGE OF STATUS

☐ **Name Change**
Former Name: _____

☐ **Employee Coverage Termination**
Date of Termination: _____

☐ **Millennium Choice Product Change**
☐ Change from DeltaPreferred Option to Select Plus
☐ Change from Select Plus to DeltaPreferred Option

☐ **DeltaCare Change Existing Clinic** New Clinic Code: _____

☒ **Coverage Change (Complete Part C)**
Reason: OPEN ENROLLMENT
Date of Change: 7-1-2023
☐ Single to Family ☐ Family to Single
☐ Add Dependent ☐ Delete Dependent

☐ **Other** _____

PART C - DEPENDENTS

Relationship	First, Middle, Last (if different from own)	Sex	Birthdate MO/DAY/YR
Spouse		M F	___/___/___
Child		M F	___/___/___
Child		M F	___/___/___
Child		M F	___/___/___

SIGNATURE BOX

I choose to make the changes indicated on this form and authorize payroll deduction where applicable.

Signature: _____ **Date:** _____

PART D – COBRA

Person Continuing Coverage: Last | First | Middle Initial

Social Security Number: ___ - ___ - ___

Sex: ☐ Male ☐ Female

Type of Coverage Requested: ☐ Single ☐ Family

Birthdate: ___ - ___ - ___

Please Indicate the Qualifying Event:
☐ Employee Death
☐ Employee Total Disability
☐ Employee Marriage Dissolution or Legal Separation
☐ Employee Eligible for Medicare
☐ Employee Termination or Reduction of Work Hours
☐ Dependent No Longer Eligible as Dependent Child

Date of Qualifying Event: _____

I have elected to continue coverage under this plan due to the qualifying event as indicated above and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or such other conditions as may be required.

Signature: _____ **Date:** _____

THIS PART TO BE COMPLETED BY EMPLOYER

Group Name: ISD #623 Roseville Area Schools

Phone Number: (651) 635-1639

Group/Account Number-Subgroup #: 506162 __ __ - __ __ __ __

Effective Date of Change: 7-1-2023