DELTA DENTAL®
Delta Dental Plan of Minnesota

Membership Enrollment 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: Address | Home Phone Number ( ) | Work Phone Number ( )

City | State | Zip Code | County

PART B – ENROLLMENT INFORMATION

Choose Coverage Type (check one box only):

- ☐ Employee only*
- ☐ Employee and spouse
- ☐ Employee and one dependent child
- ☐ Employee and two or more dependents
- ☐ No coverage*

***If waiving ANY coverage, complete Part F**

PART C – DEPENDENTS

Relationship	First, Middle, Last (if different from own)	Sex	Birthdate MO/DAY/YR	Over 19 and full-time student
Spouse		M F	/ /	☐ Yes ☐ No
Child		M F	/ /	☐ Yes ☐ No
Child		M F	/ /	☐ Yes ☐ No
Child		M F	/ /	☐ Yes ☐ No

PART D –

Select a Program: N/A

PART E – FOR DELTACARE GROUPS ONLY

Clinic Code: N/A
(obtain code from DeltaCare Provider Directory)

PART F – OTHER COVERAGE

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: _____

Policy/Identification No.: _____

Benefit Waiver (sign ONLY if declining coverage). I understand that by waiving coverage for **myself and/or my dependents**, whether entirely or partially paid by my employer, I waive the right to coordination of benefits (if applicable). I also 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.

Signature: _____ **Date:** _____

PART G – SIGNATURE BOX

I authorize payroll deduction where applicable. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages.

Signature: _____ **Date:** _____

THIS PART TO BE COMPLETED BY EMPLOYER

Indicate reason the employee is applying:

- ☐ New Group
- ☐ New Hire
- ☐ Rehire (length of layoff) _____
- ☐ Change from Part-Time to Full-Time
- ☐ Previously Waived Coverage
- ☐ Returning from Leave of Absence (length of leave) open enrollment
- ☐ Loss of Coverage
- ☐ Other

Date Above Occurred _____

Group Name ISD #623 ROSEVILLE AREA SCHOOLS Phone Number (651) 635-1639

Group/Account - Subgroup # 506162 - _____ Date Hired _____ + probationary period = Effective Date 7-1-23

Return White to Delta Dental ◆ Yellow to Employer ◆ Pink to Employee