

DENTAL ENROLLMENT / CHANGE FORM

Delta Dental Plan of Maine - Delta Dental Plan of New Hampshire - Delta Dental Plan of Vermont Please send form to: eligibility Fax - (603) 223-1252
Northeast Delta Dental - One Delta Drive - PO Box 2002 - Concord, NH 03302-2002

1-800-537-1715 - nedelta.com - (603) 223-1230 Eligibility

Be sure to fill out each section completely. Failure to complete each section in full could delay processing.

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1. GROUP INFOR	MATION - To be co	mpleted by Emp	loyer				
Group Number:	Sublocation:	С	Division:	Misc. Info	o:		Dual Option, Select Plan Low 🗌 High 🗌 N/A
Group Name:				Address			
2. SUBSCRIBER II	NFORMATION -	To be completed	d by Emp	loyee			
Date of Hire: (MM-DD-YYYY) Date of Rehire: (M-DD-YYYY) Subscriber Effective Date: (MM-DD-YYYY)				
Social Security No:	Last 1	Name:		First Na	me:		
Date of Birth: (MM-DD-Y		male 🔲 Male		ital Status: Single	Dom	estic Partner [☐ Divorced ☐ Widowed
Mailing Address:			City	:		State	e: Zip:
Email Address:					⊃hon	e Number:	
3. ENROLLMENT	OR CHANGE RE	QUEST					
Exact Date of Change:	Coverage Level Re	•	er & Spo	use 🗌 Subscriber &	Chilo	I □ Subscribe	r & Children 🔲 Family
Reason for Change:	□ New Hire □ COBRA □ Name Change: □ Open Enrollment □ Address Change						
☐ Add ☐ Delete	Marriage						
Will this dental coverage							SN and Name:
4. DEPENDENT IN List all dependents to be neligible dependents, your	ewly enrolled, or those				eletior	n. If you are enro	lling some but not all your
Last Name	First Name	DOB (MM-DD-YYYY)	Sex	Relationship to Subscriber	*	Add / Remove	Email for Spouse and/or Dependents over the age of 18
			□ F □ M	☐ Spouse☐ Domestic Partner☐ Child/Dependent		Add Remove	
			□ F □ M	☐ Child/Dependent		Add Remove	
			F M	☐ Child/Dependent		Add Remove	
		<u> </u>	F M	☐ Child/Dependent		Add Remove	
		<u> </u>	F M *Ch	☐ Child/Dependent		Add Remove	
5. COORDINATION	N OF BENEFITS			leck box ii dependent is	incap	acitated. Legai d	documentation may be required
Is there other coverage		es No	Polic	y Holder ID / Social S	ecuri	ty#:	
Carrier Name:							
understand that by not choosing date and termination date of my my employer or plan sponsor re or plan sponsor to deduct any p discontinue our coverage only	g a network provider for my y membership will be deter quires employee contribut oremium which is owed by during open enrollment, Log in to Benefit Lookup,	self or any family m mined by my emplions for this covera me as of the date r except in the ever	nember, I m oyer or pla age, I autho my applica nt of a qua	lay be responsible for higher an sponsor in accordance w orize the deductions of thes action is approved. I understa alified family status changu	out-o ith the e amo and the e. I un	f-pocket expenses underwriting guic unts from my wag at my dependents derstand that my	rect to the best of my knowledge. I also understand that the effective delines of Northeast Delta Dental. If es. I further authorize my employer and I must remain enrolled and can plan documents can be found at verage. This policy provides dental
SUBSCRIBER SIGNATUR By typing		providing a dig	gital sigr	nature to validate and	con		TE: information.