DELTA DENTAL

Delta Dental of Minnesota

Delta Dental Client - Healthcare Reform Certified Plan Eligibility Enrollment/Update Form

Client Name _____Client#/Subclient # _____-_____

PART A – PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):

Type of Update: ☐ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination ☐ Delta Dental Transfer

From: Client/Subclient # _____- _____

To: Client/Subclient # _____- _____

Effective Date of Change: _____ - _____- _____

Change is for: ☐ Subscriber ☐ Dependent ☐ Spouse/Domestic Partner

PART B – PLAN SELECTION

Select Plan: ☐ Bronze + Kids Plan ☐ Silver + Kids Plan ☐ Gold + Kids Plan ☐ Platinum + Kids Plan ☐ Kids Plan Only

PART C – SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):

Subscriber Name (Last) _____ (First) _____ (M.I.) _____ Gender _____ Status* ☐ Active ☐ COBRA ☐ Retiree ☐Surviving

Social Security Number (Requested but not Required) _____ Birth Date _____ -_____ - _____ Coverage Effective Date ____ -_____ - _____ Hire Date ____ -_____ - _____

Street Address _____ ☐ Check here if this is a new address

City _____ State _____ Zip Code _____ - _____

PART D – DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):

Spouse/Domestic Partner - Name (Last) _____ (First) _____ (M.I.) _____ Gender _____ Status* ☐ Legal ☐ Surviving

Social Security Number (Requested but not Required) _____ Birth Date _____ -_____ - _____

Dependent #1 Name (Last) _____ (First) _____ (M.I.) _____ Gender _____ Status* ☐ Legal ☐ Surviving

Social Security Number (Requested but not Required) _____ Birth Date _____ -_____ - _____ ☐ Disabled ☐ Sponsored

Dependent #2 Name (Last) _____ (First) _____ (M.I.) _____ Gender _____ Status* ☐ Legal ☐ Surviving

Social Security Number (Requested but not Required) _____ Birth Date _____ -_____ - _____ ☐ Disabled ☐ Sponsored

Dependent #3 Name (Last) _____ (First) _____ (M.I.) _____ Gender _____ Status* ☐ Legal ☐ Surviving

Social Security Number (Requested but not Required) _____ Birth Date _____ -_____ - _____ ☐ Disabled ☐ Sponsored

Dependent #4 Name (Last) _____ (First) _____ (M.I.) _____ Gender _____ Status* ☐ Legal ☐ Surviving

Social Security Number (Requested but not Required) _____ Birth Date _____ -_____ - _____ ☐ Disabled ☐ Sponsored

*see reverse side for instructions and explanation of codes

PART E - SUBSCRIBER 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

Employee Signature: _____ Date: _____

Client Representative Signature _____ Date: _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your employer continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Surviving: The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: 1) Enrolling yourself or a family member for the first time, or 2) if your benefits were terminated and are not being reinstated or, 3) if you are making changes to your current enrollment information.

Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Client Transfers: When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

Enrollment/Corrections To Information – This section should be completed when: 1) enrolling dependents or, 2) if you have checked Changes/ Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse

Surviving: The surviving spouse or child of a deceased subscriber.

Legal Dependent: An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's contract with Delta Dental.

Email: eligibility@mydeltadental.com

Delta Dental
Attention: Eligibility Department
PO Box 9124
Farmington Hills, MI 48333-9124

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota and its affiliates, (collectively referred to herein as "Delta Dental of Minnesota") comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card

If you believe that Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Minnesota, Attn: Compliance Officer, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-448-3815 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-448-3815 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-448-3815 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-448-3815 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-448-3815（TTY：711）。(Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-448-3815 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-448-3815 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-448-3815 (መስማት ለተሳናቸው: 711). (Amharic)

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤနှဲ့ ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢ် နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး

1-800-448-3815 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-448-3815 (TTY: 711). (German)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل 1-800-448-3815 (رقم 711). (Arabic)
ه الصم والبكم:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-448-3815 (ATS : 711). (French)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-448-3815 (TTY: 711)번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-448-3815 (TTY: 711). (Tagalog)

ئاگاداری: ئەگەر بە (Kurdish) تۆ بۆ، بەخۆڕایی، زمان یارمەتی خزمەتگوزاریەکانی، دەکەیت قسە کوردی زمانی بە ئەگەر بکە. بەردەستە بە 1-800-448-3815 (TTY: 711)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس 1-800-448-3815 (TTY: 711) (Persian / Farsi)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-448-3815 （TY:711）まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-448-3815 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-448-3815 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-448-3815 (TTY: 711). (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-448-3815 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षण: यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, नि:शुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-800-448-3815 (TTY: 711) मा कल गर्नुहोस्। (Nepali)