



Delta Dental Plan of Maine  
Delta Dental Plan of New Hampshire  
Delta Dental Plan of Vermont

Please send form to:

One Delta Drive  
PO Box 2002  
Concord, NH 03302-2002  
800-537-1715  
(603)223-1230 Eligibility  
(603)223-1252 Eligibility Fax  
Web site: www.nedelta.com

## ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY – IN BLUE OR BLACK INK ONLY  
AS YOUR ID CARD IS GENERATED FROM THIS FORM

### 1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. # — —	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (MM-DD-YYYY)
MAILING ADDRESS		CITY	STATE	ZIP
				TELEPHONE NO. ( )
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Other _____				

### 2. GROUP INFORMATION - To be completed by Employer/Employee

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP			
GROUP NUMBER	SUBLOCATION NUMBER	DIVISION	DENTAL EFFECTIVE DATE	
MISC. INFO (i.e. STORE LOC)	EMPLOYEE DATE OF HIRE	EMPLOYEE DATE OF REHIRE		

### 3. REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: _____		MISCELLANEOUS CHANGE:
<b>ADD:</b>	<b>DELETE:</b>	<input type="checkbox"/> Name change – Previous name: _____
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Annual Open Enrollment	<input type="checkbox"/> Transfer from sublocation _____
<input type="checkbox"/> Annual Open Enrollment	<input type="checkbox"/> Spouse's employment change	<input type="checkbox"/> Address change
<input type="checkbox"/> COBRA Due to: _____	<input type="checkbox"/> Full-time to part-time status	<input type="checkbox"/> Returning Full-Time Student
<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other _____
<input type="checkbox"/> Birth <input type="checkbox"/> Age Two	<input type="checkbox"/> Deceased	<b>COVERAGE LEVEL REQUESTED:</b>
<input type="checkbox"/> Adoption*	<input type="checkbox"/> No longer dependent for IRS purposes	<input type="checkbox"/> Employee (only) <input type="checkbox"/> Employee/Children
<input type="checkbox"/> Spouse's employment change	<input type="checkbox"/> No longer a full-time student	<input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family
<input type="checkbox"/> Part-time to full-time status	<input type="checkbox"/> Retirement	<input type="checkbox"/> Employee/Child <input type="checkbox"/> Other _____

### 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 FROM SUBSCRIBER)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	GENDER M/F	RELATION TO SUBSCRIBER	ADD / DELETE	CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT	CHECK IF DEPENDENT IS INCAPACITATED*

\*NOTE: Legal documentation is required.

### 5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent be covered under any other group dental 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	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE
DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE

I certify that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist 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 dental 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.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_