DELTA DENTAL®
Delta Dental Plan of Minnesota

Membership Enrollment Form

www.deltadentalmn.org

PART A – EMPLOYEE INFORMATION

Employee's Name:	Last		First		Middle Initial			**Social Security Number** - -	
Gender:	Male ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address					Home Phone Number ( )		Work Phone Number ( )	
	City			State		Zip Codes			

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):	**Plan Election (Required)**
☐ Employee only *(do not complete Part C)*	☐ **Delta Care Plan (Delta Care dentists only)**
☐ Family *(complete Part C)*	
☐ No Coverage	☐ **Delta Preferred Plan (includes PPO network, Premier network and out-of-network)**

PART C – DEPENDENT INFORMATION

Relationship to Employee	**First Name, Middle Initial, Last Name** (Include Last Name Only if Different From Employee's)	Gender		**Date of Birth** ***Month/Day/Year***
Spouse		M	F	/ /
Child		M	F	/ /
Child		M	F	/ /
Child		M	F	/ /
Child		M	F	/ /

PART E – EMPLOYEE SIGNATURE – ENROLLMENT

I authorize payroll deductions 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.

Employee Signature: _____ **Date:** _____

PART D – OTHER INSURANCE 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.: _____

Employee Signature: _____ **Date:** _____

Benefit Waiver (sign ONLY if declining coverage). I understand that by waiving coverage for **myself and/or my dependents (including spouse)**, 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.

Employee Signature: _____ **Date:** _____

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

Effective Date:	**Group Name**:	Group #
01/01/2019	**South Washington County Schools**	☐ **84013** ☐ **6049**