Delta Dental Plan of Minnesota

Membership Change 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 Code	

PART B – CHANGE REQUEST

☐ **Change Name:**

From: | To:

☐ **Cancellation of Coverage:**

☐ Cancel all coverage – dental insurance coverage will end 12/31/2017
☐ Cancel all dependent coverage – change from family to single coverage
☐ Cancel only these dependent(s): ______________________________

☐ **Change Plan:**

I am currently enrolled in this plan*:
☐ Delta Care Plan (Delta Care Dentists only)
☐ Delta Preferred Plan (PPO & Premier Network & out-of-network)

* If you don't know your current plan, look at your current member card, at the deduction or benefit detail of your current payroll check in ERMA, or call Delta Dental at 651-406-5916.

Change to this plan as of 01/01/18:
☐ Delta Care Plan (Delta Care Dentists only)
☐ Delta Preferred Plan (PPO & Premier Network & out-of-network)

☐ **Add Dependents to my Coverage:**

Dependent Information: Complete the following information for each dependent that you are **adding** to your coverage:

Relationship	First Name, Middle Initial, Last Name	Gender		Date of Birth	Over Age 19
Spouse		M	F	/ /	
Child		M	F	/ /	☐ Yes ☐ No
Child		M	F	/ /	☐ Yes ☐ No
Child		M	F	/ /	☐ Yes ☐ No
Child		M	F	/ /	☐ Yes ☐ No

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:**______________________

☐ **Employee Signature**

I choose to make changes as indicate on this form and authorize payroll deductions, if applicable, and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required. 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 F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

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