DELTA DENTAL®
Delta Dental Plan of Minnesota

Membership Maintenance Form

www.deltadentalmn.org

INSTRUCTIONS PROVIDED ON BACK

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: ☐ **Check if New Address**	Address	Home Phone Number ( )	Work Phone Number ( )	
	City	State	Zip Code	

PART B – CHANGE REQUEST – Check All Categories That Apply – Provide Information Requested By Category

☐ **Name Change**
Former Name: ______________________________
New Name: ______________________________

☐ **Terminate Employee and All Dependent Coverage**
Date of Termination: ________/________/________
Date Coverage Ends: ________/________/________

☐ **Currently Enrolled in:**
☐ Delta Care Plan ☐ Delta Preferred Plan

☐ **Change Choice Network at Open Enrollment to:**
☐ Delta Care Plan ☐ Delta Preferred Plan

* 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.

☐ **Enroll in Voluntary Discount Orthodontic Program – Requires Qualifying Event – Provide Details in Next Section**

Select New Coverage Type – Complete Part C if Adding or Dropping Dependents **Qualifying Event Code: A** – Adoption **B** – Birth **D** – Divorce/Legal Separation **E** – Death **L** – Loss of Coverage **M** – Marriage **S** – Dependent No Longer Eligible

Qualifying Event Code	Change Request Category (Complete Qualifying Event Code for Each Request)	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /

PART C – DEPENDENT INFORMATION – Adding or Dropping Dependents May Require a Coverage Type Change in Part B

Add	Drop	Relationship To Employee	First Name, Middle Name, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Over Age 19 and Full-Time Student
		Spouse		M	F	/ /	
		Child		M	F	/ /	☐Yes ☐No
		Child		M	F	/ /	☐Yes ☐No
		Child		M	F	/ /	☐Yes ☐No

PART D – EMPLOYEE SIGNATURE

I choose to make changes as indicated on this form and authorize payroll deductions, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated above 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.

Employee Signature: **Date:**

PART E – COBRA – Employee Note : Complete ONLY if enrolling for COBRA benefits **Employer Note** – May require subgroup change.

Qualifying Event Number:
1 Employee Termination or Reduction of Work Hours
2 Employee Death
3 Employee Total Disability
4 Divorce or Legal Separation
5 Employee Eligible For Medicare
6 Dependent No Longer Eligible

Coverage Continuation Applies To:	Event Number	Date of Qualifying Event	Social Security Number
☐ Employee & All Dependents Currently Enrolled		/ /	
☐ Employee Only		/ /	
☐ Spouse Only		/ /	- -
☐ Dependent(s) Only – List Names in Part C		/ /	- -
☐ Employee & Spouse		/ /	
☐ Employee & Dependent Child(ren)-List Names in Part C		/ /	

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

Group Name: **South Washington County Schools** **Group & Subgroups Numbers:** ===

Group Representative's Signature: **Date:** **Phone Number: ( )**

◆Return Original to Employer◆Retain a Copy for Your Records◆

Instructions for Completion of Membership Maintenance Form

Important Notes:

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Before submitting, review to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned and may delay your enrollment.
- Enrollment request are generally completed within five business days of receipt by Delta Dental Plan of Minnesota.

Part A: Employee Information – Complete all sections.

Part B: Change Request

- **Name Change –** Provide name as previously reported and new name.
- **Terminate Employee and All Dependents** – Only use this section if the employee and all dependent coverage is being terminated.
- **Change Employee Group/Subgroup** – Move employee from one group/subgroup to another for benefit, report or COBRA purposes.
- **Change Millennium Choice Network** – Use for employees currently enrolled to select new Network during group's Open Enrollment.
- **Change DeltaCare Clinic Code** – List new clinic code found in DeltaCare Provider Directory.
- **Enroll in Voluntary Discount Orthodontic Program** – Applies only to groups offering this program. Enrollment requires a qualifying event. Part B must be completed with *Qualifying Event Code* and *Dates.*
- **Coverage Type Change –** Complete this section to change *Coverage Type* and to add or drop dependent coverage. Provide detailed information for each dependent being added or dropped in Part C.

Part C: Dependent Information

- List dependents to be added or dropped if requested in Part B.
- Complete all sections for each dependent.
- If more than four dependents are being reported, attached a list of additional dependent information in same format.

Part D: Employee Signature

- Please read and sign form as verification of your change request.
- Return completed form to your benefit administrator.

Part E: COBRA - Complete this section only if an individual has selected continuation of coverage under COBRA.

- Select a *Coverage Type*, the appropriate *Qualifying Event Number, Date of Qualifying Event* and Effective *Date of Coverage.*
- If employee is not enrolling for COBRA, provide Social Security Number of individual who is being enrolled.
- If group has a separate COBRA subgroup, it must be provided in Part B.

Part F: Group Information – Completed By Employer

- **Group Name –** Provide group name as listed in your contract
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative –** Sign, date and provide your phone number.