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 Design Type (Check One Box Only):
☐ Employee only	☐ Delta Care Plan
☐ Family	☐ Delta Preferred Plan

PART C – DEPENDENT INFORMATION - Please complete for each dependent being covered:

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	/ /
Child		M	F	/ /
Child		M	F	/ /

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:** ____________________

PART E – EMPLOYEE SIGNATURE

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

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