DELTA DENTAL

Delta Dental of Nebraska
Membership Enrollment Form

PART A – EMPLOYEE INFORMATION Employee complete Parts A thru E and return form to benefit administrator.

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 – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):

☐ Employee only*
☐ Employee and Spouse
☐ Employee and Dependent Child(ren)
☐ Family
☐ No Coverage*

***If waiving coverage for employee and/or any eligible family members, you must complete Part D.**

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	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
Child		M	F	/ /	☐ Yes ☐ No

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.: _____

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

☐ **New Group** – Initial Group Enrollment Effective Date: _____/_____/_____	☐ **Rehire** - Length of Lay Off:_____ Date Rehired:_____/_____/_____	☐ **Other** - Reason:_____ Effective Date: _____/_____/_____
☐ **Open Enrollment** Effective Date:_____/_____/_____	☐ **Return from Leave of Absence** Length of Leave: _____ Date Returned to Work:____/_____/_____	☐ **Employee Change Part Time to Full Time** Date of Change: _____/_____/_____ Effective Date: _____/_____/_____
☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date Hire Date: _____/_____/_____ Effective Date:_____/_____/_____	☐ **Loss of Coverage** – Employee and/or Dependent Date of Loss: _____/_____/_____ Effective Date: _____/_____/_____	☐ **Previously Waived Coverage** Qualifying Event Reason:_____ Event Date: _____/_____/_____ Effective Date: _____/_____/_____

Group Name: **Group & Subgroup Numbers**: **---**

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

◆ Send Original Copy to Delta Dental◆ Retain Copy For Your Records ◆ E61 08/25/06

Employer Instructions

- Review Parts A, B, C, D, and E to be sure all information is complete, accurate and legible.
- 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).
- Delta Dental of Nebraska generally completes enrollment requests within five business days of receipt.

Employer Complete Part: F - Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer to Delta Dental and submitting initial employee enrollment. Note: For a New Group enrolling a Direct Billed COBRA participant, check *Other* category. Provide reason and original date of qualifying event and correct COBRA subgroup. If information is not provided, participant will not be enrolled and billed properly.
- **Open Enrollment** – Employee is enrolling during group's open enrollment period.
- **New Hire** – Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Other** – Use if enrollment situation is not included in another category. Provide a specific reason and event date.
- **Previously Waived Coverage** – If an employee waives coverage, they can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage.
- **Employee Status Change** – Employee's employment status changed and employee is now eligible for dental benefits.
- **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.

Send Completed Forms To:
Delta Dental of Nebraska
Attn: Enrollment Department
PO Box 330
Minneapolis MN 55440-0330