



# DENTAL ENROLLMENT / CHANGE FORM

Delta Dental Plan of Maine - Delta Dental Plan of New Hampshire - Delta Dental Plan of Vermont  
Please send form to: [eligibilitydepartment@nedelta.com](mailto:eligibilitydepartment@nedelta.com) or Eligibility Fax - (603) 223-1252  
Northeast Delta Dental - One Delta Drive - PO Box 2002 - Concord, NH 03302-2002 - 1-800-537-1715 - [nedelta.com](http://nedelta.com) - (603) 223-1230 Eligibility

**Be sure to fill out each section completely. Failure to complete each section in full could delay processing.**

**1. GROUP INFORMATION - To be completed by Employer**

Group Number: \_\_\_\_\_ Sublocation: \_\_\_\_\_ Division: \_\_\_\_\_ Misc. Info: \_\_\_\_\_ If Dual Option, Select Plan:  Low  High  N/A

Group Name: \_\_\_\_\_ Address: \_\_\_\_\_

**2. SUBSCRIBER INFORMATION - To be completed by Employee**

Date of Hire: (MM-DD-YYYY) \_\_\_\_\_ Date of Rehire: (MM-DD-YYYY) \_\_\_\_\_ Subscriber Effective Date: (MM-DD-YYYY) \_\_\_\_\_

Social Security No: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Female  Male Marital Status:  Single  Married  Domestic Partner  Divorced  Widowed

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**3. ENROLLMENT OR CHANGE REQUEST**

Exact Date of Change: (MM-DD-YYYY) \_\_\_\_\_ Coverage Level Requested:  Subscriber Only  Subscriber & Spouse  Subscriber & Child  Subscriber & Children  Family

Reason for Change:  New Hire  Open Enrollment  Marriage  Birth/Adoption  COBRA  Address Change  Loss of Coverage  Employment Change

Add  Delete

Name Change:  Name Change: \_\_\_\_\_  
 Transfer from Sublocation: \_\_\_\_\_  
 Other/Explain: \_\_\_\_\_

Will this dental coverage replace another Northeast Delta Dental Plan? If yes, provide the Subscriber ID/SSN and Name: \_\_\_\_\_

**4. DEPENDENT INFORMATION**  
List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion. If you are enrolling some but not all your eligible dependents, your other dependents must have coverage elsewhere.

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Sex	Relationship to Subscriber	*	Add/Remove	Email for Spouse and/or Dependents over the age of 18
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child/Dependent	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Child/Dependent	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Child/Dependent	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Child/Dependent	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Child/Dependent	<input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove	

**\*Check box if dependent is incapacitated. Legal documentation may be required.**

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. By signing below I hereby accept coverage. This policy provides dental benefits only. Review your policy carefully.

**SUBSCRIBER SIGNATURE (REQUIRED):** \_\_\_\_\_ **DATE:** \_\_\_\_\_