DELTA DENTAL

ENROLLMENT FORM

Please print.

Delta Dental of Rhode Island
PO Box 1517
Providence, RI 02901-1517
800-84-DELTA

Employer Group Name	Delta Dental Group Number	Date of Hire	Location No. (if applicable)

Social Security No. / Subscriber I.D. No.	Subscriber Name: First - Last

Date of Birth - MM/DD/YYYY	Street Address / P.O. Box No.	Email Address

Effective Date of Action:	Apt. No.	City	State	Zip

QUALIFYING EVENT

- ____ Open Enrollment
- ____ New Hire/Re-hire
- ____ Marriage
- ____ Divorce
- ____ Birth or Adoption
- ____ Workers' Compensation
- ____ Return From Leave of Absence
- ____ Dependent's Loss of Coverage
- ____ Full-Time/Part-Time Status
- ____ Death of a Member

ACTION CODE (Check one. *Changes must be made on the first of the month.*)

ADDITIONS:

- ____ New Subscriber
- ____ Add Dependent to Family
- ____ Reinstatement

TERMINATION:

- ____ Remove Subscriber
- ____ Remove Dependent / Student (List dependent name.)

STATUS CHANGE:

- ____ Individual to Family
- ____ Family to Individual
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:

- ____ Reinstatement of Subscriber
- ____ Addition of Dependent — (From prior ID # _____)

DEPENDENT INFORMATION

Full Name (First, Last)	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

CORRECTIONS / OTHER REMARKS

TYPE OF COVERAGE (Check one) ☐ Individual ☐ Family

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ☐ No ☐ Yes **If Yes, Please Complete the Section Below.**

Other Dental Insurance Name: _____ Type of Coverage: ☐ Individual ☐ Family

Other Dental Insurance Address: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ☐ No ☐ Yes **If Yes, Please Complete the Section Below.**

Name of Medical Insurance Company/HMO: _____ Type of Coverage: ☐ Individual ☐ Family

Name of Health Plan/Type of Coverage: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.

I certify that all information is true and correct to the best of my knowledge. Also, I 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 Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ **Date** _____ **Benefits Administrator Authorization** _____ **Date** _____

SUBMIT TO DELTA DENTAL