DELTA DENTAL®

ENROLLMENT FORM

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517
800-84-DELTA

Please print

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.

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)*

Explain in "Other Remarks" if necessary.

ADDITIONS:

_____ New Subscriber
_____ Add Dependent to Existing Family Coverage
_____ 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
_____ Add Dependent: - (From Prior Subscriber ID # _____)

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
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☐ **Corrections / Other Remarks** (Please Explain)

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