DELTA DENTAL®

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

ENROLLMENT FORM

I. SUBSCRIBER INFORMATION

Subscriber Name (First, Last)		Date of Birth (MM/DD/YYYY)	Social Security / I.D. #	
Street Address / P.O. Box No.	Apt. No.	City	State	Zip
Email Address				

II. GROUP INFORMATION

Employer / Group Name	Date of Hire	Group No.	Division No.	Location No. (if applicable)

III. ENROLLMENT INFORMATION

EFFECTIVE DATE OF ACTION (MM/DD/YYYY)

QUALIFYING EVENT

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

ACTION CODE

Check one.
Changes typically made on the first of the month.

ADDITIONS
- ☐ New Subscriber
- ☐ Add Dependent to Family
- ☐ Reinstatement

TERMINATION
- ☐ Remove Subscriber
- ☐ Remove Dependent
  List name in Section IV

STATUS CHANGE
- ☐ Name / Address Change
- ☐ Transfer from Sublocation # _____ to # _____
- ☐ Change Type of Coverage (*Please indicate change, e.g. Individual to Family, in "Type of Coverage" section below.)*

COBRA
- ☐ Reinstatement of Subscriber
- ☐ Addition of Dependent
  Prior ID # _____

TYPE OF COVERAGE

Check one.

- ☐ Individual
- ☐ Family

IV. DEPENDENT INFORMATION

First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Check if student over 19*
				☐
				☐
				☐
				☐
				☐
				☐

***Group must have student rider.**

V. COORDINATION OF BENEFITS

Are you or any of your dependents covered by another DENTAL plan? ☐ No ☐ Yes *If Yes, please complete the section below.*

Policyholder Name (First, Last)	Policyholder I.D. No.	Group I.D. No.
Dental Insurance Company	Dental Insurance Address (Street, City, State, Zip)	
Employer Name *(through which you/your dependents have coverage)*		

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. 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 _____

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Delta Dental of Rhode Island does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-3582.

Português (Portuguese): ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.