



Delta Dental Plan of Maine Delta Dental Plan of New Hampshire Delta Dental Plan of Vermont

DENTAL ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY - IN BLUE OR BLACK INK ONLY

Please send form to: Northeast Delta Dental One Delta Drive PO Box 2002 Concord, NH 03302-2002 1-800-537-1715 (603)223-1230 Eligibility (603)223-1252 Eligibility Fax

								w	/ww.nedelta.com	
1. SUBSCRIBER INFORMATION		Employee								
LAST NAME (SUBSCRIBER)	FIRST NAME	FIRST NAME		SOCIAL SECUR	SOCIAL SECURITY / I.D. #			(□F	DATE OF BIRTH (MM-DD-YYYY)	
MAILING ADDRESS		CITY			STATE	ZIP)		TELEPHONE NO.	
MARITAL STATUS SING	VED STIC PARTNER	OR			E-MAIL ADDRESS TO RECEIVE HEALTH THROUGH ORAL WELLNESS® (HOW®) MESSAGES					
2. GROUP INFORMATION - To b	be completed by Empl	oyer								
GROUP NAME		STREET AD	DRESS,	CITY, STATE, ZIP						
GROUP NUMBER	SUBLOCATION NUMBER			DIVISION				MISC. INFO (i.e. STORE LOC)		
EFFECTIVE DATE (MM-DD-YYYY)	, ,			EMPLOYEE DATE OF REHIRE (MM-DD-YYYY)				IF DUAL OPTION, SELECT PLAN □ N/A □ LOW □ HIGH		
3. REASON FOR ENROLLMENT	/CHANGE - Check all	appropriate box	ces							
EXACT DATE OF STATUS CHANGE ADD: New enrollment Annual open enrollment COBRA Due to: Marriage Birth Other: Adoption Employment change for spouse Part-time to full-time employment s	DELETE: Annual open enrous propertion of the properties of the pr	istatus [MISCELLANEOUS CHANGE: Name change – Previous name:							
4. DEPENDENT INFORMATION above in section #3. If you are 6	 List all dependents enrolling some but no 	to be newly enr	olled, or ible dep	r those depender endents, vour ot	nts who a her depe	re aff ndent	ected by	an ad	dition or deletion listed overage elsewhere.	
LAST NAME (IF DIFFERENT)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	SEX		нір	ADD DELET	/ E	E-MAIL FOR SPOUSE AND/OR PENDENTS OVER THE AGE OF 18	L FOR SPOUSE AND/OR	
			<u> </u>		$\perp \downarrow \downarrow$					
			<u> </u>		$\dashv \downarrow$		\bot			
			<u> </u>		$\dashv \downarrow$		\bot			
			<u> </u>		$\perp \downarrow \downarrow$					
- OTHER ORGUN COVERACE	(OSOBBINATION OF	DENEETC)		*Check if depend	dent is inc	apacit	ated. Lega	al docu	umentation may be required.	
5. OTHER GROUP COVERAGE	•			7 ,						
Will this dental coverage replace anot		l Plan?	Yes ∟	No If yes, com	 			- /B4B4	BB VVVV	
POLICYHOLDER ID # / SOCIAL SECURITY #						EFFECTIVE DATE (MM-DD-YYYY)				
Statements made in this documen I understand that by not choosing a effective date and termination date of Dental. If my employer or plan sponimy employer or plan sponsor to ded enrolled and can discontinue our cover This policy provides dental benefits	network provider for myse of my membership will be d sor requires employee conduct any premium which is verage only during open en	self or any family m determined by my e ontributions for this s owed by me as on nrollment, except in	nember, I employer coverage of the date	may be responsible or or plan sponsor in a le, I authorize the de e my application is a	e for higher accordance eductions of approved.	r out-o e with t of these I unde	of-pocket ex the underw e amounts rstand that	expense writing of from r t my de	es. I also understand that the guidelines of Northeast Delta my wages. I further authorize ependents and I must remain	
SUBSCRIBER SIGNATURE (REQUIF		DATE:								