



**Delta Dental of Nebraska
Membership Enrollment Form**

PART A – EMPLOYEE INFORMATION Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:		Last		First		Middle Initial		Social Security Number	
								/ /	
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Legally Separated <input type="checkbox"/>	Date of Birth (Month-Day-Year)
								/ /	
Employee's Address:	Address			Home Phone Number			Work Phone Number		
				()			()		
		City		State		Zip Code			

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		*If waiving coverage for employee and/or any eligible family members, complete Part D.	
<input type="checkbox"/> Employee only*	<input type="checkbox"/> Family	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> No Coverage*
<input type="checkbox"/> Employee and Dependent Child(ren)			

PART C – DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
		M	F		Y	N	Y	N
Spouse		M	F	/ /				
Child		M	F	/ /	Y	N	Y	N
Child		M	F	/ /	Y	N	Y	N
Child		M	F	/ /	Y	N	Y	N
Child		M	F	/ /	Y	N	Y	N

PART D – OTHER INSURANCE COVERAGE

Do you (the employee) have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Carrier: _____	Policy/Identification No.: _____
Benefit Waiver (sign ONLY if declining coverage). I understand that by waiving coverage for myself and/or my dependents , whether entirely or partially paid by my employer, I waive the right to coordination of benefits (if applicable). I also waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.	
Employee Signature: _____	Date: _____

PART E – EMPLOYEE SIGNATURE

I authorize payroll deductions where applicable. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages.
Employee Signature: _____
Date: _____

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> New Group Hire Date: ____/____/____ Prior Coverage Start Date (if applicable): ____/____/____ Coverage Effective Date: ____/____/____	<input type="checkbox"/> Rehire Date Lay Off Began: ____/____/____ Date Rehired: ____/____/____
<input type="checkbox"/> Existing Delta Dental Group Hire Date: ____/____/____ Prior Coverage Start Date (if applicable): ____/____/____ Coverage Effective Date: ____/____/____	<input type="checkbox"/> Return from Leave of Absence Date Leave Began: ____/____/____ Date Returned to Work: ____/____/____
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Effective Date Hire Date: ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Employee Change Part Time to Full Time Date of Status Change: ____/____/____ Effective Date: ____/____/____
<input type="checkbox"/> Open Enrollment Effective Date: ____/____/____	<input type="checkbox"/> Previously Waived Coverage or Loss of Coverage Qualifying Event Reason: _____ Hire Date: ____/____/____ Event Date: ____/____/____ Effective Date: ____/____/____
Group Name: _____	Group & Subgroup Numbers: ---
Group Representative's Signature: _____	Date: _____ Phone Number: () _____

Employer Instructions

- Review Parts A, B, C, D, and E to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Delta Dental of Nebraska generally completes enrollment requests within five business days of receipt.

Employer Complete Part: F - Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer to Delta Dental and submitting initial employee enrollment. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies. Note: For a New Group enrolling a Direct Billed COBRA participant, write Direct Bill in the New Group section. If information is not provided, participant will not be enrolled and billed properly.
- **Existing Delta Dental Group** – Enrolling additional employees from an acquisition/merger who were not previously offered/enrolled in you Delta Dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **New Hire** – Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- **Open Enrollment** – An employee is enrolling during group's open enrollment period.
- **Rehire** – A former employee was rehired.
- **Return From Leave of Absence** – An employee is returning from leave of absence.
- **Employee Status Change** – The employee's employment status changed and the employee is now eligible for dental benefits.
- **Previously Waived Coverage or Loss of Coverage** – If an employee waives coverage, he/she can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage. If an employee or dependent involuntarily losses coverage and are now eligible to enroll, complete this section.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Forms To:

Delta Dental of Nebraska
Attn: Enrollment Department
PO Box 330
Minneapolis MN 55440-0330