



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: | | Date of Birth (Month-Day-Year) |
| | | | Single <input type="checkbox"/> | Married <input type="checkbox"/> | Widowed <input type="checkbox"/> |
| | | | Divorced <input type="checkbox"/> | Legally Separated <input type="checkbox"/> | / / |
| 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): | | |
| <input type="checkbox"/> Employee only* | <input type="checkbox"/> Family | *If waiving coverage for employee and/or any eligible family members, you must complete Part D. |
| <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 <small>(Include Last Name Only if Different From Employee's)</small> | Gender | Date of Birth Month/Day/Year | Over Age 19 and Full-Time Student |
|--------------------------|---|--------|---------------------------------|--|
| Spouse | | M F | / / | |
| Child | | M F | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child | | M F | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child | | M F | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child | | M F | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PART D – OTHER INSURANCE COVERAGE

Do you (the employee) have other dental coverage? Yes No Do your dependents have other dental coverage? Yes 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 – Initial Group Enrollment | <input type="checkbox"/> Rehire - Length of Lay Off: _____ | <input type="checkbox"/> Other - Reason: _____ |
| Effective Date: ____/____/____ | Date Rehired: ____/____/____ | Effective Date: ____/____/____ |
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Return from Leave of Absence | <input type="checkbox"/> Employee Change Part Time to Full Time |
| Effective Date: ____/____/____ | Length of Leave: _____ | Date of Change: ____/____/____ |
| | Date Returned to Work: ____/____/____ | Effective Date: ____/____/____ |
| <input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Effective Date | <input type="checkbox"/> Loss of Coverage – Employee and/or Dependent | <input type="checkbox"/> Previously Waived Coverage |
| Hire Date: ____/____/____ | Date of Loss: ____/____/____ | Qualifying Event Reason: _____ |
| Effective Date: ____/____/____ | Effective 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. Note: For a New Group enrolling a Direct Billed COBRA participant, check *Other* category. Provide reason and original date of qualifying event and correct COBRA subgroup. If information is not provided, participant will not be enrolled and billed properly.
- **Open Enrollment** – Employee is enrolling during group's open enrollment period.
- **New Hire** – Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Other** – Use if enrollment situation is not included in another category. Provide a specific reason and event date.
- **Previously Waived Coverage** – If an employee waives coverage, they 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.
- **Employee Status Change** – Employee's employment status changed and employee is now eligible for dental benefits.
- **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