



Delta Dental of Nebraska Membership Maintenance Form

PART A - EMPLOYEE INFORMATION

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									
								()			()									
<input type="checkbox"/> Check If New Address		City			State			Zip Code												

PART B - CHANGE REQUEST - Check All Categories That Apply - Provide Information Requested By Category

<input type="checkbox"/> Name Change			
Former Name: _____			
New Name: _____			
<input type="checkbox"/> Change Employee Group/Subgroup (move individual to different subgroup, including COBRA subgroup)		<input type="checkbox"/> Terminate Employee and All Dependent Coverage	
From: _____ To: _____		Date of Termination: _____ / _____ / _____	
Effective Date of Change: _____ / _____ / _____		Date Coverage Ends: _____ / _____ / _____	
Select New Coverage Type - Complete Part C if Adding or Dropping Dependents Qualifying Event Code: A - Adoption B - Birth D - Divorce/Legal Separation E - Death L - Loss of Coverage M - Marriage S - Dependent No Longer Eligible			
Qualifying Event Code	Change Request Category (Complete Qualifying Event Code for Each Request)	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /

PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type Change in Part B

Add	Drop	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	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

PART D - EMPLOYEE SIGNATURE

I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated above and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

Employee Signature: _____ **Date:** _____

PART E - COBRA - Employee Note: Complete Only if enrolling for COBRA benefits Employer Note - May require subgroup change

Qualifying Event Number:			
1 Employee Termination or Reduction of Work Hours		3 Employee Total Disability	
2 Employee Death		4 Divorce or Legal Separation	
		5 Employee Eligible For Medicare	
		6 Dependent No Longer Eligible	
Coverage Continuation Applies To:		Event Number	Date of Qualifying Event
<input type="checkbox"/> Employee & All Dependents Currently Enrolled			/ /
<input type="checkbox"/> Employee Only			/ /
<input type="checkbox"/> Spouse Only			/ /
<input type="checkbox"/> Dependent(s) Only - List Names in Part C			/ /
<input type="checkbox"/> Employee & Spouse			/ /
<input type="checkbox"/> Employee & Dependent Child(ren)-List Names in Part C			/ /
			- -
			- -

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

Group Name: _____	Group & Subgroup Numbers: _____
Group Representative's Signature: _____	Date: _____ Phone Number: () _____

Instructions for Completion of Membership Maintenance Form

Important Notes:

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format.
- 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).
- Before submitting, review it to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned to you and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt by Delta Dental of Nebraska.

Part A: Employee Information - Complete all sections.

Part B: Change Request

- **Name Change** – Provide name as previously reported and new name.
- **Terminate Employee and All Dependents** – Only use this section if the employee and all dependent coverage is being terminated.
- **Change Employee Group/Subgroup** – Move employee from one group/subgroup to another for benefit, report or COBRA purposes.
- **Coverage Type Change** – Complete this section to change *Coverage Type* and to add or drop dependent coverage. Provide detailed information for each dependent being added or dropped in Part C.

Part C: Dependent Information

- List dependents to be added or dropped if requested in Part B.
- Complete all sections for each dependent.
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

Part D: Employee Signature

- Please read and sign form as verification of your change request.
- Return completed form to your benefit administrator.

Part E: COBRA – Complete this section only if an individual has selected continuation of coverage under COBRA.

- Select a *Coverage Type*, the appropriate *Qualifying Event Number*, *Date of Qualifying Event* and *Effective Date of Coverage*.
- If employee is not enrolling for COBRA, provide Social Security Number of individual who is being enrolled.
- If group has a separate COBRA subgroup, it must be provided in Part B.

Part F: Group Information – Completed By Employer

- **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