Delta Dental Plan of Minnesota

Membership Enrollment Form

www.deltadentalmn.org

Independent School District 196 Group/Subgroup #: 476-001

SECTION 1 -- EMPLOYEE INFORMATION (Please complete in full and print clearly.)

Employee Last Name	First	MI	Social Security Number	
Street Address			Marital Status ☐ Single ☐ Married	
City	State	Zip Code	Date of Birth	☐ Male ☐ Female
Home Phone Number ( ) -	Work Phone Number ( ) -		Effective Date	Employee #

SECTION 2 -- DENTAL ENROLLMENT (Please check desired coverage)

I **elect** coverage for:

☐ Employee
☐ Family

Dependent Information: *(Please complete if you are enrolling dependents for coverage)*

Last Name (If different from above)	First Name	MI	Relationship to employee	Date of birth (Mo/Day/Yr)	Sex (M,F)	Social Security Number (required)
Spouse:			Spouse			
Dependent(s):						

SECTION 3 – 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 Number: ______________________________

SECTION 4 -- SIGNATURE (Employee must sign and date.)

CONDITIONS OF COVERAGE:

I hereby apply for coverage on the basis of the statements and answers to the questions herein. **BY SIGNING THIS FORM I CERTIFY THAT ALL OF THE STATEMENTS ABOVE ARE TRUE.**

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **I understand that my election is irrevocable for the plan year, unless I experience a qualifying event & notify the plan in writing within 30 days of the date of the qualifying event.**

EMPLOYEE SIGNATURE ______________ DATE SIGNED ______________

PLAN ADMINISTRATOR SIGNATURE ______________ DATE SIGNED ______________