DELTA DENTAL

Membership Maintenance Form

www.deltadentalmn.org

INSTRUCTIONS PROVIDED ON BACK

PART A - EMPLOYEE INFORMATION

ISD 15 Employee Number (if known): ____________________

Employee's Name:	Last	First	Middle Initial	Social Security Number
Gender: Male ☐ Female ☐	**Marital Status:** Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐			**Date of Birth (Month-Day-Year)**
Employee's Address:	Address	Home Phone Number ( )	Work Phone Number ( )	
☐ **Check If New Address**	City	State	Zip Code	

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

☐ **Name Change**
Former Name: ______________________________
New Name: ______________________________

☐ **Terminate Employee and All Dependent Coverage**
Date of Termination: ______________________________
Date Coverage Ends: ______________________________

☐ **Change Employee Group/Subgroup** (Move individual to different subgroup, including to COBRA subgroup)
From: ________________ To: ____________________
Effective Date of Change: ____________________

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		☐ Yes ☐ No
		Child		M	F		☐ Yes ☐ No
		Child		M	F		☐ Yes ☐ 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
2 Employee Death
3 Employee Total Disability
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	Social Security Number
☐ Employee & All Dependents Currently Enrolled			
☐ Employee Only			
☐ Spouse Only			
☐ Dependent(s) Only – List Names in Part C			
☐ Employee & Spouse			
☐ 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 Minnesota.

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.

Return Completed Forms to:

Human Resources, Benefits
District Office