



# ENROLLMENT FORM

Delta Dental of Rhode Island  
P.O. Box 1517  
Providence, RI 02901-1517  
800-84-DELTA

Please print.

Employer Group Name	Delta Dental Group Number	Date of Hire	Location No. (if applicable)
Social Security No. / Subscriber I.D. No.	Subscriber Name: First - Last		
Date of Birth - MM/DD/YYYY	Street Address / P.O. Box No.		
Effective Date of Action:	Apt. No.	City	State      Zip

**QUALIFYING EVENT**

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Return From Leave of Absence
<input type="checkbox"/> Marriage	<input type="checkbox"/> Dependent's Loss of Coverage
<input type="checkbox"/> Divorce	<input type="checkbox"/> Full-Time/Part-Time Status
<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Death of a Member

**DEPENDENT INFORMATION**

First Name Only <small>If last name differs, please indicate in "other remarks" below.</small>	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

**ACTION CODE** (Check One) *(Changes must be made on the first of the month)*  
Explain in "Other Remarks" if necessary.

**ADDITIONS:**

New Subscriber

Add Dependent to Existing Family Coverage

Reinstatement

**TERMINATION:**

Remove Subscriber

Remove Dependent/Student (List dependent name.)

**STATUS CHANGE:**

<input type="checkbox"/> Individual to Family	<input type="checkbox"/> Individual to 2 Person
<input type="checkbox"/> Family to Individual	<input type="checkbox"/> 2 Person to Individual
<input type="checkbox"/> Name / Address Change	<input type="checkbox"/> Family to 2 Person
<input type="checkbox"/> Transfer from Sublocation # _____ to # _____	<input type="checkbox"/> 2 Person to Family

**COBRA:**

Reinstatement of Subscriber

Add Dependent: - (From Prior Subscriber ID # \_\_\_\_\_)

**Type of Coverage** (Check One)     Individual     2 Person     Family

**Corrections / Other Remarks** (Please Explain)

### COORDINATION OF BENEFITS

**DENTAL** — Are You or Any of Your Dependents Covered by Another Dental Plan?     No     Yes    If Yes, Please Complete the Section Below.

Other Dental Insurance Name: \_\_\_\_\_      Type of Coverage:     Individual     Family

Other Dental Insurance Address: \_\_\_\_\_

Employer Name Through Which You/Your Dependents Have Other Insurance: \_\_\_\_\_

Group Policy No.	Policyholder Name	Policyholder ID No.
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**MEDICAL** — Are You or Any of Your Dependents Covered by A Medical Plan?     No     Yes    If Yes, Please Complete the Section Below.

Name of Medical Insurance Company/HMO: \_\_\_\_\_      Type of Coverage:     Individual     Family

Name of Health Plan/Type of Coverage: \_\_\_\_\_

Employer Name Through Which You/Your Dependents Have Other Insurance: \_\_\_\_\_

Group Policy No.	Policyholder Name	Policyholder ID No.
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*I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.*

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Benefits Administrator Authorization \_\_\_\_\_ Date \_\_\_\_\_

## Easy to Manage Dental Benefits Make Everyone Smile

Keeping your account's information up-to-date is important to ensure your employees get the most out of their benefits, so we work to keep your plan as easy to manage as possible.

### Here are a few quick hints for common procedures.

#### **Enrollment:** Adding/Deleting Employees

The only time you can add or delete employees other than during open enrollment is for a new hire, a terminated employee, or during a qualifying event. These include:

- Marriage
- Birth or Adoption
- Family Medical or Disability Leave
- Full Time/Part Time Status
- Divorce Worker's Compensation
- Worker's Compensation
- Spouse's Loss of Coverage
- Death of a Member

**Please note:** When submitting a status change (such as individual to family coverage) other than during open enrollment, please explain the reason for the change in the enrollment form's "comments" section (either the online or paper version), to expedite processing the change.

#### **Retroactive Policy:** Delta Dental has a 30-day retroactive policy for adding or terminating employees from your plan.

Retroactivity occurs when we are notified of an addition, change or termination after the requested effective date has passed. However, if we paid a claim after the requested retroactive termination date, your employee will be terminated on the last day of the month in which the claim was paid.

**Helpful reminder for administrators filing paper forms:** As the Benefit Administrator, you should complete and sign all enrollment forms for your employees and mail them to the P.O. Box listed on the form. (If you file electronically, your transactions are already authorized.) Be sure to include the following:

- Your group policy number
- Your group name
- The action code on the form
- The effective date of the change
- The employee's subscriber number and birth date

### Billing: Eligibility Changes and Payments

**Monthly Invoice:** You'll receive a monthly invoice approximately 10 days before the first of the month, reflecting current and prior billing information, payment information from the prior month, and any reported eligibility changes. Your invoice shows a cutoff date for any enrollment and payments received.

**Premiums due:** Payment is due in advance on the first of each month to cover that month's premium.

### Don't Forget Automatic Payment Options!

Another time and money-saving service we offer is the ability to have your monthly premium automatically deducted from your bank account. No more late payments, coverage lapses, or monthly check-writing hassles. Contact Billing Services to find out how to get started: 401-752-6200 or 800-598-6684.