DELTA DENTAL®

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

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

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:

_____ Individual to Family
_____ Family to Individual
_____ Name / Address Change
_____ Transfer from Sublocation #_____ to #_____
_____ Individual to 2 Person
_____ 2 Person to Individual
_____ Family to 2 Person
_____ 2 Person to Family

COBRA:

_____ Reinstatement of Subscriber
_____ Add Dependent: - (From Prior Subscriber ID # _____)

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

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
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❑ **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.

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.

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 _____

SUBMIT TO DELTA DENTAL

DELTA DENTAL

Administrative *Tips*

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**.