DELTA DENTAL

ST. OLAF COLLEGE

Delta Dental of Minnesota

Membership Enrollment/Change Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru G and return form to benefit administrator.

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		Day Phone Number	Evening Phone Number
	City	State	Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type – Who Is Being Enrolled – Check One Box Only
* If waiving coverage for employee and/or eligible family members, complete Part F.

- ☐ Employee only*
- ☐ Employee and Spouse
- ☐ Employee and Dependent Child(ren)
- ☐ Family
- ☐ No Coverage*

PART C – DEPENDENT INFORMATION

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	Full Time Student?		Unmarried?	
		Spouse		M	F	/ /				
		Dependent Child		M	F	/ /	Y	N	Y	N
		Dependent Child		M	F	/ /	Y	N	Y	N
		Dependent Child		M	F	/ /	Y	N	Y	N
		Dependent Child		M	F	/ /	Y	N	Y	N
		Dependent Child		M	F	/ /	Y	N	Y	N
		Dependent Child		M	F	/ /	Y	N	Y	N

PART F – OTHER INSURANCE COVERAGE – Complete if employee and/or eligible dependents are not being enrolled.

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: ____________________________

PART G – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment

Employee Electronic Signature Usage Agreement:
When electronic signatures are used, federal law requires that we inform you of the following:

- By signing below, I consent to electronic processing of this application to include use of my electronic signature.
- I acknowledge that Electronic Signature means that I am the person identified on this application as the applicant, that I voluntarily accept all the terms and conditions as stated in this application, and that I agree to the electronic processing of this record.
- I acknowledge that my electronic signature will have the same legal effect as a signature on paper.
- I acknowledge that I have the right to print and keep this application on paper.
- I acknowledge that I have the right to withdraw my consent to the electronic signature on this application. I understand I must notify my benefit providers in writing of my withdrawal of consent and that such withdrawal will not affect actions already taken by my benefit providers.
- I acknowledge that my consent to the use of my electronic signature applies to this application only and not to any other transactions with my benefit providers. I hereby apply for coverage on the basis of the statements and answers to the questions herein.

I hereby declare all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. Furthermore, I understand that this application must be updated by me to include any condition of disease which may occur between the date of my application and the Effective Date of Coverage. I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified for the Effective Date.

Employee Enrollment Acceptance:
I choose to make changes as indicated on this form 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 Agree to the Usage Agreement and Acceptance statements mentioned above.

Employee Signature: ____ **Date:** _______________

PART H – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

Group Name: St. Olaf College	**Group & Subgroup Numbers**:001155-	
Group Representative's Signature: Travis Grant, Benefits Specialist	**Date:**	**Phone Number:** (507) 786-6689

◆Send Original Copy to Delta Dental + Retain Copy For Your Records +