



Northeast Delta Dental

One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800-537-1715
603-223-1230 Eligibility
603-223-1252 Eligibility Fax

ENROLLMENT / CHANGE FORM

PLEASE PRINT LEGIBLY OR TYPE - IN BLUE OR BLACK INK ONLY

Web site: www.nedelta.com

NEDD USE ONLY

1. GROUP INFORMATION
GROUP NAME, STREET ADDRESS, CITY, STATE, ZIP
GROUP NUMBER, SUBLLOCATION, DIVISION, EFFECTIVE DATE
MISC. INFO (i.e. STORE LOC), DATE OF HIRE, DATE OF REHIRE

2. REASON FOR SUBMISSION
Please check the box next to the reason for change:
ADD DELETE
New, Annual Open Enrollment, Name change, Transfer from sublocation, Address change only, COBRA, Other

STATUS CHANGE: EXACT DATE OF EVENT: COVERAGE LEVEL:
Marriage, Birth, Adoption, Spouse's employment change, Part-time to full-time status
Divorce, Deceased, No longer dependent for IRS purposes, Retirement, Other
Employee, Employee/Spouse, Employee/Child, Employee/Children, Employee/Family, Other

3. SUBSCRIBER INFORMATION
LAST NAME (SUBSCRIBER), FIRST NAME, SOCIAL SECURITY / I.D. #, GENDER, DATE OF BIRTH
STREET ADDRESS, CITY, STATE, ZIP, TELEPHONE NO.

MARITAL STATUS
SINGLE MARRIED DIVORCED LEGALLY SEPARATED WIDOWED Other

4. LIST ALL DEPENDENTS TO BE ENROLLED OR AFFECTED BY A CHANGE
Table with columns: LAST NAME (IF DIFFERENT FROM SUBSCRIBER), FIRST NAME, DATE OF BIRTH, GENDER M/F, RELATION TO SUBSCRIBER, CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT, *CHECK IF DEPENDENT IS INCAPACITATED

*NOTE: Legal documentation required (i.e., adoption, incapacitated dependent)

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? Yes No
If yes, complete the following:

OTHER DENTAL INSURANCE COMPANY, EMPLOYER NAME, POLICY HOLDER ID NO., EFFECTIVE DATE
COVERED INDIVIDUALS

I certify that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also 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 Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any dental premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and be dropped only during open enrollment, except in the event of a qualified family status change.

SIGNATURE DATE