ENROLLMENT FORM

Please print.

Delta Dental of Rhode Island
PO Box 1517
Providence, RI 02901-1517
800-84-DELTA

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.	Email Address

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.*)

ADDITIONS:

- ☐ New Subscriber
- ☐ Add Dependent to Family
- ☐ Reinstatement

TERMINATION:

- ☐ Remove Subscriber
- ☐ Remove Dependent / Student (List dependent name.)

STATUS CHANGE:

- ☐ Change "Type of Coverage"
  Please indicate change (e.g. Individual to Family) in the section below.
- ☐ Name / Address Change
- ☐ Transfer from Sublocation #_____ to #_____

COBRA:

- ☐ Reinstatement of Subscriber
- ☐ Addition of Dependent — (From prior ID # _____)

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship

CORRECTIONS / OTHER REMARKS

TYPE OF COVERAGE (Check one)

☐ Individual ☐ Individual & Spouse ☐ Individual & Child(ren) ☐ Family

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 _____

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Delta Dental of Rhode Island does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingü.stica. Llame al 1-800-843-3582.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.