



Dental Flex Membership Enrollment Form

Delta Dental of Nebraska

PART A – EMPLOYEE INFORMATION – Employee complete parts A thru D 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				Home Phone Number		Work Phone Number			
	City				State		Zip Code			

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):

Employee Only*
 No Coverage*

Employee and Spouse

Employee and Dependent Child(ren)

Family

*** If waiving coverage for employee and/or any eligible family members, you must complete Part D.**

PART C – DEPENDENT INFORMATION

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	Over Age 19 and Full-Time Student
Spouse		M	F	/ /	
Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART D – EMPLOYEE SIGNATURE – Select One

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

I am enrolling myself and/or my dependents and authorize payroll deductions where applicable. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages.

Employee Signature: _____ **Date:** _____

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

<input type="checkbox"/> New Group Hire Date: ____/____/____ Prior Coverage Start Date (if applicable): ____/____/____ Dental Flex Coverage Effective Date: ____/____/____		<input type="checkbox"/> Rehire Date Lay Off Began: ____/____/____ Date Rehired: ____/____/____	
<input type="checkbox"/> Existing Delta Dental Group Hire Date: ____/____/____ Prior Coverage Start Date (if applicable): ____/____/____ Dental Flex Coverage Effective Date: ____/____/____		<input type="checkbox"/> Return from Leave of Absence Date Leave Began: ____/____/____ Date Returned to Work: ____/____/____	
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Effective Date Hire Date: ____/____/____ Effective Date: ____/____/____		<input type="checkbox"/> Loss of Coverage – Employee and/or Dependent Hire Date: ____/____/____ Date of Loss: ____/____/____ Effective Date: ____/____/____	
<input type="checkbox"/> Previously Waived Coverage Qualifying Event Reason: _____ Hire Date: ____/____/____ Event Date: ____/____/____ Effective Date: ____/____/____			
Group Name: _____		Group & Subgroup Numbers: ---	
Group Representative's Signature: _____		Date: _____ Phone Number: () _____	

Employer Instructions

- Review Parts A, B, C, and D to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Delta Dental of Nebraska generally completes enrollment requests within five business days of receipt.

Employer Complete Part: E - Group Enrollment Information

- Review sections completed by employee to assure information provided is complete, accurate and legible.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer to Delta Dental and submitting initial employee enrollment. Complete all dates:
 - Hire Date – date employee was employed by group
 - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Date does not apply if group did not previously have a qualified dental plan. When applicable, provide date employee enrolled in group's prior dental plan.
- **Existing Delta Dental Group** – Existing Delta Dental customer changing benefits to Dental Flex product and submitting employee enrollment.
 - Hire Date – date employee was employed by group
 - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Date does not apply if group did not previously have a qualified dental plan. When applicable, provide date employee enrolled in group's prior dental plan
- **New Hire** – Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was laid off and is being rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Previously Waived Coverage** – Enrolled employee had eligible family status change such as: marriage, divorce, birth, adoption, which allows dependents to be added.
- **Employee Status Change** – Employee's employment status changed and employee is now eligible for dental benefits.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Forms To:

Delta Dental of Nebraska
Attn: Enrollment Department
PO Box 330
Minneapolis MN 55440-0330