



DELTA DENTAL PLAN OF MAINE
DELTA DENTAL PLAN OF NEW HAMPSHIRE
DELTA DENTAL PLAN OF VERMONT

NORTHEAST DELTA DENTAL
One Delta Drive
PO Box 2002
Concord, New Hampshire 03302-2002
(603) 223-1000 Corporate
(603) 223-1230 Eligibility
(603) 223-1252 Eligibility Fax

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

1 EMPLOYEE INFORMATION

LAST NAME (17 CHARACTERS ONLY) FIRST NAME (8 CHARACTERS ONLY) BIRTHDATE MO DAY YEAR

SOCIAL SECURITY # SEX (M/F) MARITAL STATUS (SINGLE/MARRIED/DIVORCED/LEGALLY SEPARATED/WIDOWED)

ADDRESS CITY STATE ZIP

TELEPHONE # () DATE OF HIRE DATE OF REHIRE

EMPLOYER NAME ADDRESS

GROUP NUMBER SUBLOCATION NUMBER EFFECTIVE DATE

2 REASON FOR APPLICATION (CHECK APPROPRIATE BOXES) ADD DELETE

- NEW, ANNUAL OPEN ENROLLMENT, CHANGE OF NAME/ADDRESS, CHANGE OF STATUS, EXACT DATE OF EVENT, CHANGE IN STATUS DUE TO: MARRIAGE, BIRTH, ADOPTION, SPOUSE'S EMPLOYMENT CHANGE, NO LONGER DEPENDENT FOR IRS PURPOSES, RETIREMENT, DIVORCE, LEGAL SEPARATION, DEATH, OTHER

NOTE: IF ENROLLING ONE ELIGIBLE DEPENDENT, ALL MUST BE ENROLLED. IF ENROLLING DEPENDENT CHILDREN OVER 19 PLEASE INDICATE NEXT TO NAME IF DEPENDENT IS A STUDENT OR INCAPACITATED.

3 DEPENDENT INFORMATION NOTE: LIST ONLY DEPENDENTS FOR WHOM CHANGE OF STATUS IS REQUESTED

Table with columns: LAST NAME, FIRST, INITIAL, SEX, BIRTHDATE, RELATIONSHIP

4 TYPE OF COVERAGE (PLEASE CHECK ONE)

- 1 - EMPLOYEE ONLY, 2 - EMPLOYEE & SPOUSE, 3 - EMPLOYEE, SPOUSE & CHILDREN, 5 - EMPLOYEE & CHILD, 6 - EMPLOYEE & CHILDREN

5 PREVIOUS/EXISTING COVERAGE

WILL THIS DENTAL COVERAGE REPLACE ANOTHER NORTHEAST DELTA DENTAL PLAN? YES NO
IF YES, GROUP NO. SOCIAL SECURITY NO. OF PERSON COVERED
WILL YOU OR ANY OF YOUR FAMILY MEMBERS HAVE DENTAL COVERAGE FROM ANOTHER DENTAL PLAN? YES NO
IF YES, NAME OF THE INSURER POLICY NO.
EFFECTIVE DATE OF PLAN SINGLE TWO PERSON FAMILY

THIS INFORMATION IS REQUIRED SO THAT DELTA MAY COORDINATE BENEFITS WITH THE OTHER CARRIER SO THAT YOU MAY BENEFIT FROM DUAL COVERAGE.

6 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 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 UNDERSTAND THAT MY DEPENDENTS MUST REMAIN ENROLLED AND BE DROPPED ONLY DURING CONTRACT REOPENING, EXCEPT IN THE EVENT OF FAMILY STATUS CHANGE.

SIGNATURE DATE