

Dental Membership Enrollment Form Instructions

Important Information: 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 purposes of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Important notes:

- all dates should be written in MM/DD/YYYY format.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., first of the month, end of month, or actual dates).
- Before submitting, review it to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned to you and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt of Northeast Delta Dental Plans.

PART A: EMPLOYEE INFORMATION (complete all sections)

PART B: CHANGE REQUEST (check one or more categories that apply and provide information as requested by category)

- Name Change - Provide name as previously reported and new name.
- Terminate Employee and All Dependents - Only use this section if the employee **and** all dependent coverage is being terminated.
- Change Employee Group/Subgroup - Move employee from one group/subgroup number to another for benefit, reporting or COBRA purposes.
- Change Plan Option - Applies only to employer groups that offer more than one Plan Option and have Open Enrollment. An employee may select a new Plan Option during the Group's Open Enrollment.
- Coverage Type Change - Complete this section to change Coverage Type and to add or drop dependent coverage. Coverage Type change requires a qualifying event (i.e., marriage, divorce, etc.). List Qualifying Event Code on line next to correct Coverage Type. Provide detailed information for each dependent being added or dropped in Part C.

PART C: DEPENDENT INFORMATION

- List dependents to be added or dropped when making a change to Coverage Type in Part B.
- Complete all sections for each dependent.
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

PART D: EMPLOYEE SIGNATURE: Please read, sign and date the form as verification of your change request, then return completed form to Karen Thames in Payroll.

SECTION 125 CAFETERIA PLAN BENEFIT ELECTION FORM This cafeteria plan allows participants to make payments for certain employer-sponsored benefits plans with pre-tax dollars. By agreeing to reduce your salary by the amount of your contribution, you will generate Benefit Account Dollars which are not subject to FICA or federal and state income taxes. Any election you make to fund your benefits under the provisions of this plan will remain in effect until the end of the plan year unless one of the following family status changes occurs, in which event an election may be revoked or changed.

- legal marital status including marriage, divorce, legal separation or annulment
- death of a spouse or death of a dependent child
- change in employment status (employee, spouse or dependent) from commencement of work, full-time to part-time or vice versa, unpaid leave of absence, strike or lockout or termination of employment affecting eligibility under an employee benefit plan
- a change in residence of the employee, spouse or dependent that affects eligibility coverage
- dependent satisfies or ceases to satisfy dependent eligibility requirements