



Northeast Delta Dental
 One Delta Drive
 PO Box 2002
 Concord, NH 03302-2002
 800-537-1715
 www.nedelta.com

Delta Dental Plan of Maine
 Delta Dental Plan of New Hampshire, Inc.
 Delta Dental Plan of Vermont, Inc.

CHANGE FORM FOR INDIVIDUAL DENTAL BENEFITS

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

Last Name: _____ First Name: _____ SS#: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth (mm/dd/yyyy): _____ Telephone: () _____

E-Mail: _____ Group No.: _____ Subloc. No. _____

REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: _____

- | | | |
|---|--|--|
| ADD:
<input type="checkbox"/> Marriage
<input type="checkbox"/> Child
<input type="checkbox"/> Adoption*
<input type="checkbox"/> Spouse's employment change | DELETE:
<input type="checkbox"/> Divorce
<input type="checkbox"/> No longer a student
<input type="checkbox"/> Deceased
<input type="checkbox"/> Spouse's employment change | MISCELLANEOUS CHANGE:
<input type="checkbox"/> Name change – Previous name: _____
<input type="checkbox"/> Address change
<input type="checkbox"/> Other _____ |
|---|--|--|

* Legal documentation is required.

DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

ADD	DELETE	LAST NAME	FIRST NAME	DATE OF BIRTH mm/dd/yyyy	GENDER M/F	RELATION TO SUBSCRIBER	CHECK IF DEPENDENT IS AGE 19 TO 25 AND A STUDENT	*CHECK IF DEPENDENT IS INCAPACITATED

* Legal documentation is required.

ENROLLMENT TYPE - A change in enrollment type will lead to a rate change.

Select Enrollment Type

- Subscriber Only
 Subscriber/Spouse or Subscriber/Child
 Subscriber/Family or Subscriber/Children

CHANGE BILLING AND PAYMENT METHOD TO:

- Standard Billing and Payment Method:** Monthly bill payable with check or money order.
 Optional Billing and Payment Method: See Payment Option Form included.

Subscriber Signature _____ Date _____