DELTA DENTAL®

DeltaVision®

Red Tree Insurance Company, Inc.

DeltaVision® ENROLLMENT / CHANGE FORM

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

Please send form to:
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
1-800-537-1715
(603)223-1230 Eligibility
(603)223-1252 Eligibility Fax
www.nedelta.com

1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. #	SEX ○ M ○ F	DATE OF BIRTH (MM-DD-YYYY)

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.

MARITAL STATUS ○ SINGLE ○ WIDOWED ○ DIVORCED ○ DOMESTIC PARTNER ○ MARRIED

E-MAIL ADDRESS

2. GROUP INFORMATION - To be completed by Employer

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP

GROUP NUMBER	SUBLOCATION NUMBER	DIVISION	MISC. INFO (i.e. STORE LOC)

EFFECTIVE DATE (MM-DD-YYYY)	EMPLOYEE DATE OF HIRE (MM-DD-YYYY)	EMPLOYEE DATE OF REHIRE (MM-DD-YYYY)

3. REASON FOR ENROLLMENT/CHANGE - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE (MM-DD-YYYY) _____

ADD:
- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ COBRA Due to:
- ☐ Marriage
- ☐ Birth ☐ Other:
- ☐ Adoption
- ☐ Employment change for spouse
- ☐ Part-time to full-time employment status

DELETE:
- ☐ Annual open enrollment
- ☐ Employment change for spouse
- ☐ Full-time to part-time employment status
- ☐ Divorce
- ☐ Deceased
- ☐ Retirement
- ☐ Other Coverage
- ☐ Other_____

MISCELLANEOUS CHANGE:
- ☐ Name change – Previous name: _____
- ☐ Transfer from sublocation: _____
- ☐ Address change
- ☐ Other: _____

COVERAGE LEVEL REQUESTED
- ☐ Subscriber Only ☐ Subscriber & Spouse ☐ Subscriber & Child
- ☐ Subscriber & Children ☐ Family

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3.

LAST NAME (IF DIFFERENT)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	SEX M/F	RELATIONSHIP TO SUBSCRIBER	*	ADD/ DELETE	E-MAIL FOR SPOUSE AND/OR DEPENDENTS OVER THE AGE OF 18

***Check if dependent is incapacitated. Legal documentation may be required.**

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also 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 further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. **By signing below I hereby accept coverage. This policy provides vision benefits only. Review your policy carefully.**

SUBSCRIBER SIGNATURE (REQUIRED): _____ DATE: _____

DeltaVision is underwritten by Red Tree Insurance Company, Inc., a Northeast Delta Dental company. Claims processing, claims service and provider network administration for DeltaVision are provided, under contract, by EyeMed Vision Care, LLC and its affiliate, First American Administrators, Inc.