DELTA DENTAL®

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

ENROLLMENT / CHANGE FORM FOR CONTINUATION OF COVERAGE

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
800-537-1715
(603)223-1230 Eligibility
(603)223-1252 Eligibility Fax
Web site: www.nedelta.com

Applicant and dependents may only apply if not covered under another dental plan.

SUBSCRIBER INFORMATION

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

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED / CIVIL UNION PARTNER ☐ DIVORCED ☐ WIDOWED ☐ OTHER _____

E-MAIL

Complete the following segment *only for dependents who are either newly enrolled or are affected by a deletion listed below.*

LAST NAME	FIRST NAME	DATE OF BIRTH mm/dd/yyyy	GENDER M/F	RELATION TO SUBSCRIBER	CHECK IF DEPENDENT IS INCAPACITATED*

***Legal documentation required.**

REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: _____ – – (mm-dd-yyyy)

ADD:
☐ New enrollment

DELETE:
☐ Employment change for spouse/ civil union partner
☐ Deceased
☐ Divorce/Termination of a civil union
☐ No longer student

MISCELLANEOUS CHANGE:
☐ Name change – Previous name: _____
☐ Address change

COVERAGE LEVEL REQUESTED

☐ Subscriber (only)
☐ Subscriber/Spouse/ Civil Union Partner
☐ Subscriber/Child
☐ Subscriber/Children
☐ Subscriber/Family
☐ Other _____

BILLING AND PAYMENT METHOD[1]

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

I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist for myself or any family member, I may be responsible for higher out-of-pocket expenses. 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.

SIGNATURE _____ DATE _____

[1]**New Hampshire residents and Vermont residents who are eligible for the ARRA subsidy**

FOR NORTHEAST DELTA DENTAL USE ONLY

Group Number: _____ Premium: _____ Elig: _____

Effective Date: _____ Term Date: _____ BA: _____