



## Delta Dental of North Carolina Membership Maintenance Form

### PART A - EMPLOYEE INFORMATION

<b>Employee's Name:</b>		Last		First		Middle Initial		<b>Social Security Number</b>	
		/		/		/			
<b>Gender:</b>	Male	Female	<b>Marital Status:</b>	Single	Married	Widowed	Divorced	Legally Separated	<b>Date of Birth (Month-Day-Year)</b>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
<b>Employee's Address:</b>	Address					Day Phone Number		Evening Phone Number	
	<input type="checkbox"/> <b>Check If New Address</b>	City			State		Zip Code		

### PART B - CHANGE REQUEST - Check all categories that apply and provide information requested by category.

<input type="checkbox"/> <b>Name Change</b>			
Former Name: _____			
New Name: _____			
<input type="checkbox"/> <b>Change Employee Group/Subgroup</b> (Move individual to different subgroup, including to COBRA subgroup)	<input type="checkbox"/> <b>Terminate Employee and All Dependent Coverage</b>		
From: _____ To: _____	Date of Termination: ____/____/____		
Effective Date of Change: ____/____/____	Date Coverage Ends: ____/____/____		
<input type="checkbox"/> <b>Change Coverage Type, Add or Drop Dependent Due to Qualifying Event</b> - List Qualifying Event Code next to correct Coverage Type/Change Request Category. Complete Part C if Adding or Dropping Dependent(s). <b>Qualifying Event Code:</b> A - Adoption B - Birth D - Divorce/Legal Separation E - Death L - Loss of Coverage M - Marriage O - Open Enrollment S - Dependent No Longer Eligible			
<b>Qualifying Event Code</b>	<b>Coverage Type / Change Request Category</b>	<b>Date of Qualifying Event</b>	<b>Effective Date of Change</b>
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /
	Add or Drop Dependent - No Coverage Type Change	/ /	/ /

### PART C - DEPENDENT INFORMATION - Adding or dropping dependents may require a Coverage Type change in Part B.

Add Drop	Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
			M	F		Y	N	Y	N
	Spouse		M	F	/ /				
	Dependent Child		M	F	/ /	Y	N	Y	N
	Dependent Child		M	F	/ /	Y	N	Y	N

### PART D - EMPLOYEE SIGNATURE - Sign and date form as verification of your enrollment change.

I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated below and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### PART E - COBRA - Employee Note: Complete Only if enrolling for COBRA benefits Employer Note: May require subgroup change.

**Qualifying Event Number:**

1 Employee Termination or Reduction of Work Hours	3 Employee Total Disability	5 Employee Eligible For Medicare
2 Employee Death	4 Divorce or Legal Separation	6 Dependent No Longer Eligible

Coverage Continuation Applies To:	Event Number	Date of Qualifying Event	Social Security Number
<input type="checkbox"/> Employee & All Dependents Currently Enrolled		/ /	
<input type="checkbox"/> Employee Only		/ /	
<input type="checkbox"/> Spouse Only		/ /	- -
<input type="checkbox"/> Dependent(s) Only - List Names in Part C		/ /	- -
<input type="checkbox"/> Employee & Spouse		/ /	
<input type="checkbox"/> Employee & Dependent Child(ren)-List Names in Part C		/ /	

### PART F - GROUP INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

<b>Group Name:</b> _____	<b>Group &amp; Subgroup Numbers:</b> _____
<b>Group Representative's Signature:</b> _____	<b>Date:</b> _____ <b>Phone Number:</b> _____

# Instructions for Completion of Membership Maintenance Form

## Important Notes:

- Type or print clearly with a pen.
- 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., 1<sup>st</sup> of 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 by Delta Dental of North Carolina.

**Part A: Employee Information** - Complete all sections.

## Part B: Change Request

- **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 to another for benefit, report or COBRA purposes.
- **Change Coverage Type, Add or Drop Dependent Due to Qualifying Event** – Complete this section to change *Coverage Type* and/or to add or drop dependent's coverage. Provide detailed information for each dependent being added or dropped in Part C.

## Part C: Dependent Information

- List and complete all sections for each dependent to be added or dropped, if requested in Part B
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

## Part D: Employee Signature

- Please read and sign form as verification of your change request.
- Return completed form to your benefit administrator.

## Part E: COBRA – Complete this section only if an individual has selected continuation of coverage under COBRA.

- Select a *Coverage Type*, the appropriate *Qualifying Event Number*, *Date of Qualifying Event* and *Effective Date of Coverage*.
- If employee is not enrolling for COBRA, provide Social Security Number of individual who is being enrolled.
- If group has a separate COBRA subgroup, it must be provided in Part B.

## Part F: Group Information – Completed By Employer

- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

### Send Completed Forms To:

Delta Dental of North Carolina  
Attn: Enrollment Department  
PO Box 9342  
Minneapolis MN 55440-9342