DELTA DENTAL®

HOW® HEALTH through ORAL WELLNESS®
1-800-537-1715 or 1-603-223-1230
www.nedelta.com

Delta Dental Plan of Maine
Delta Dental Plan of New Hampshire
Delta Dental Plan of Vermont

DENTAL ENROLLMENT / CHANGE FORM

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

Empl ID:_____

Please bring form to Human Resource Services in 228 Waterman or email to hrsinfo@uvm.edu

1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY	SEX	DATE OF BIRTH (MM-DD-YYYY)
			○ M ○ F	

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.

MARITAL STATUS ○ SINGLE ○ WIDOWED ○ DIVORCED ○ MARRIED

Select Plan ○ Basic ○ High Option

E-MAIL ADDRESS TO RECEIVE HEALTH THROUGH ORAL WELLNESS® (HOW®) MESSAGES

2. GROUP INFORMATION - To be completed by Employer

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP
University of Vermont	85 South Prospect Street, Burlington, VT 05405

GROUP NUMBER	SUBLOCATION NUMBER		
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. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	SEX M/F	RELATIONSHIP TO SUBSCRIBER	*	ADD/ DELETE	

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

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will this dental coverage replace another Northeast Delta Dental Plan? ○ Yes ○ No **If yes, complete the following:**

POLICYHOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY)

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 dental benefits only. Review your policy carefully.**

SUBSCRIBER SIGNATURE (REQUIRED): _____ DATE: _____