

I. SUBSCRIBER INFORMATION

Subscriber Name (First, Last)		Date of Birth (MM/DD/YYYY)	EMPLOYEE ID#	
Street Address / P.O. Box No.	Apt. No.	City	State	Zip
Email Address		Date of Hire	Phone	

II. GROUP INFORMATION **HR WILL COMPLETE THIS, SKIP AHEAD TO SECTION 3**

Employer / Group Name	Group No.	Division No.	Location No. (if applicable)
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III. ENROLLMENT INFORMATION

EFFECTIVE DATE OF ACTION (MM/DD/YYYY) *Benefits are effective the first of the month after your hire date or the date of a qualifying event (except birth/adoption). Open Enrollment changes are effective July 1st.*

QUALIFYING EVENT

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Return from Leave of Absence	<input type="checkbox"/> Full-Time/Part-Time Status
<input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Divorce	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Loss of Coverage	<input type="checkbox"/> Death of a Member

ACTION CODE

ADDITIONS	TERMINATION	STATUS CHANGE	COBRA
<input type="checkbox"/> New Subscriber	<input type="checkbox"/> Remove Subscriber	<input type="checkbox"/> Name/ Address Change	<input type="checkbox"/> Reinstatement of Subscriber
<input type="checkbox"/> Add Dependent to Family	<input type="checkbox"/> Remove Dependent <i>List name in Section IV</i>	<input type="checkbox"/> Transfer from Sublocation # _____ to # _____	<input type="checkbox"/> Addition of Dependent <i>Prior ID # _____</i>
<input type="checkbox"/> Reinstatement		<input type="checkbox"/> Change Type of Coverage <i>(Please indicate change, e.g Individual to Family, in "Type of Coverage" section below.)</i>	

TYPE OF COVERAGE Individual Family
Check one.

IV. DEPENDENT INFORMATION

First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Check if student over 19*
				<input type="checkbox"/>

*Group must have student rider.

V. COORDINATION OF BENEFITS

Are you or any of your dependents covered by another DENTAL plan? No Yes *If Yes, please complete the section below.*

Policyholder Name (First, Last)	Policyholder I.D. No.	Group I.D. No.
Dental Insurance Company	Dental Insurance Address (Street, City, State, Zip)	
Employer Name <i>(through which you/your dependents have coverage)</i>		

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. If my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ Date _____ Benefits Administrator Authorization _____ Date _____

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Delta Dental of Rhode Island does not discriminate on the basis of race, color, national origin, age, disability, or sex
Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-3582.
Português (Portuguese): ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.