



DENTAL INSURANCE ENROLLMENT / CHANGE FORM

(Administered by Delta Dental of New Hampshire)

Please send form to:

City of Manchester
Human Resources/Benefits
One City Hall Plaza
Manchester, NH 03101
Phone (603) 624-6543
Fax (603) 628-6065
benefitscoordinator@manchesternh.gov

PLEASE TYPE OR PRINT LEGIBLY – IN BLUE OR BLACK INK ONLY
AS YOUR ID CARD IS GENERATED FROM THIS FORM

1. SUBSCRIBER INFORMATION – To be completed by Employee				
LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY/ I.D. #	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
MAILING ADDRESS		CITY	STATE	ZIP
TELEPHONE NO.				
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER				

2. GROUP INFORMATION – To be completed by Employer/Employee			
GROUP NAME City of Manchester	STREET ADDRESS, CITY, STATE, ZIP One City Hall Plaza, Manchester New Hampshire, 03101		
GROUP NUMBER 3203	SUBLOCATION NUMBER	DIVISION N/A	DENTAL EFFECTIVE DATE
MISC. INFO (i.e. STORE LOC) N/A	EMPLOYEE DATE OF HIRE	EMPLOYEE DATE OF REHIRE	

3. REASON FOR SUBMISSION – Check all appropriate boxes	
<p>EXACT DATE OF STATUS CHANGE: _____</p> <p>ADD:</p> <p><input type="checkbox"/> New Enrollment</p> <p><input type="checkbox"/> Annual Open Enrollment</p> <p><input type="checkbox"/> COBRA Due to: _____</p> <p><input type="checkbox"/> Marriage *</p> <p><input type="checkbox"/> Birth <input type="checkbox"/> Age Two</p> <p><input type="checkbox"/> Adoption*</p> <p><input type="checkbox"/> Spouse's employment change</p> <p><input type="checkbox"/> Part-time to full-time status</p>	<p>DELETE:</p> <p><input type="checkbox"/> Annual Open Enrollment</p> <p><input type="checkbox"/> Spouse's employment change</p> <p><input type="checkbox"/> Full-time to part-time status</p> <p><input type="checkbox"/> Divorce</p> <p><input type="checkbox"/> Deceased</p> <p><input type="checkbox"/> No longer dependent for IRS purposes</p> <p><input type="checkbox"/> No longer a full-time student</p> <p><input type="checkbox"/> Retirement</p> <p>MISCELLANEOUS CHANGE:</p> <p><input type="checkbox"/> Name change - Previous Name _____</p> <p><input type="checkbox"/> Transfer from sublocation _____</p> <p><input type="checkbox"/> Address change</p> <p><input type="checkbox"/> Returning Full-Time Student</p> <p><input type="checkbox"/> Other _____</p> <p>COVERAGE LEVEL REQUESTED:</p>

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 (IF DIFFERENT FROM SUBSCRIBER)	FIRST NAME	DATE OF BIRTH	GENDER	RELATION TO SUBSCRIBER	ADD/DELETE	CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT	*CHECK IF DEPENDENT IS INCAPACITATED
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>

*NOTE: Legal documentation is required.

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)		
Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Will this dental coverage replace another Northeast Delta Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes to either question, complete the following:		
DENTAL INSURANCE COMPANY	POLICY HOLDER ID# / SOCIAL SECURITY #	EFFECTIVE DATE
DENTAL INSURANCE COMPANY	POLICY HOLDER ID# / SOCIAL SECURITY #	EFFECTIVE DATE

I certify 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 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 dental 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.

SIGNATURE _____ **DATE:** _____