DELTA DENTAL
Delta Dental of Rhode Island

ENROLLMENT FORM

P.O. Box 1517
Providence, RI 02901-1517
800-84-DELTA

Please print. Complete form to ensure enrollment.

Employer Group Name	Delta Dental Group Number	Date of Hire	Location No. (if applicable)
Barrington Public Schools		/ /	

Social Security No. / Subscriber I.D. No.	Subscriber Name: First (8 Characters) Last (16 Characters)

Date of Birth	Street Address / P.O. Box No.
/ /	

Effective Date of Action:	Apt. No.	City	State	Zip
/ /				

QUALIFYING EVENT

- ____ Open Enrollment
- ____ New Hire/Re-hire
- ____ Marriage
- ____ Divorce
- ____ Birth or Adoption
- ____ Workers Compensation
- ____ Family Medical or Disability Leave
- ____ Spouse's Loss of Coverage
- ____ Full Time/Part Time Status
- ____ Death of a Member

ACTION CODE (Check One) *(Changes must be made on the first of the month)*
Explain in "Other Remarks" if necessary.

ADDITIONS:

- ____ New Subscriber
- ____ Add Dependent to Family
- ____ Reinstatement

TERMINATION:

- ____ Remove Subscriber
- ____ Remove Dependent / Student

STATUS CHANGE:

- ____ Individual to Family
- ____ Family to Individual
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:

- ____ Reinstatement of Subscriber
- ____ Addition of Dependent — (From prior ID # _____)

Type of Coverage (Check One) ❑ Individual ❑ Family

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Student Rider (over age 19)
Spouse		Please check box below if full-time student.
Children		☐
		☐
		☐
		☐
		☐
		☐
		☐

❑ **Corrections / Other Remarks** (Please Explain)

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ❑ No ❑ Yes If Yes, Please Complete the Section Below.

Other Dental Insurance Name: _____ Type of Coverage: ❑ Individual ❑ Family

Other Dental Insurance Address: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policy Holder Name	Policy Holder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ❑ No ❑ Yes If Yes, Please Complete the Section Below.

Name of Medical Insurance Company/HMO: _____ Type of Coverage: ❑ Individual ❑ Family

Name of Health Plan/Type of Coverage: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policy Holder Name	Policy Holder ID No.

I certify that all information is true and correct to the best of my knowledge. Also, I 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 Delta Dental. In addition, 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 _____

SUBMIT TO DELTA DENTAL