

I. SUBSCRIBER INFORMATION					
Subscriber Name (First, Last)		Date of Birth (MM/DD/YYYY)		Social Security / I.D. #	
Street Address / P.O. Box No.		Apt. No.	City	State	Zip
Email Address					
II. GROUP INFORMATION					
Employer / Group Name		Date of Hire	Group No.	Division No.	Location No. (if applicable)
III. ENROLLMENT INFORMATION					
EFFECTIVE DATE OF ACTION (MM/DD/YYYY)					
QUALIFYING EVENT	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce	<input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Return from Leave of Absence <input type="checkbox"/> Loss of Coverage	<input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Death of a Member
ACTION CODE <i>Check one. Changes typically made on the first of the month.</i>	<u>ADDITIONS</u> <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement	<u>TERMINATION</u> <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent <i>List name in Section IV</i>	<u>STATUS CHANGE</u> <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____ <input type="checkbox"/> Change Type of Coverage (Please indicate change, e.g. <i>Individual to Family, in "Type of Coverage" section below.)</i>	<u>COBRA</u> <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent <i>Prior ID # _____</i>	
TYPE OF COVERAGE <i>Check one.</i>	<input type="checkbox"/> Individual <input type="checkbox"/> Family				
IV. DEPENDENT INFORMATION					
First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Check if student over 19*	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

*Group must have student rider.

V. COORDINATION OF BENEFITS		
Are you or any of your dependents covered by another DENTAL plan? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If Yes, please complete the section below.</i>		
Policyholder Name (First, Last)	Policyholder I.D. No.	Group I.D. No.
Dental Insurance Company	Dental Insurance Address (Street, City, State, Zip)	
Employer Name (through which you/your dependents have coverage)		

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, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.