

Please select and read the instructions below that apply to the changes you are making:

You may complete the form either by typing directly onto the form (use your TAB key to navigate) or just print off and handwrite your choices.

To Enroll:

1. Complete sections:
 - A. Employee Information
 - B. Dependent Information
 - C. Membership choices: Select the coverage you wish to enroll, i.e. dental choice, single/family.
 - D. Complete only if you will be covered by another insurance over the next year in addition to Concordia's coverage
 - E. Print the form and sign this section
2. Mail or bring the form to the Office of Human Resources.

To Drop Coverage:

1. Complete sections:
 - A. Employee Information
 - C. Check Terminate Coverage box(es). Print and sign the waiver line.
2. Mail or bring the form to the Office of Human Resources.

To Change Status of your Coverage:

1. Complete sections:
 - A. Employee Information
 - B. Dependent Information
 - C. Membership Choices: Select the coverage you wish to change to, i.e. dental choice, single/family.
 - D. Complete only if you will be covered by another insurance over the next year in addition to Concordia's coverage
 - E. Print the form and sign this section
2. Mail or bring the form to the Office of Human Resources.

PART A – EMPLOYEE INFORMATION

Employee's Name	Last	First	M.I.	Social Security Number
Employee's Home Address	Address		City	State
	Day Phone Number (w/ area code) ()		Evening Phone Number (w/ area code) ()	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Date of Birth (M / D / Y)

PART B – DEPENDENT INFORMATION

Relationship to Employee	First	M.I.	Last (if different from employee)	Social Security Number	New Dependent	Gender (M/F)	Date of Birth M/D/Y	Over Age 19 & Full Time Student
Spouse					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Dependent children age 19 to age 25 must be full-time students to be covered by Concordia College's medical/dental plan; these dependents however do not qualify for the Ortho portion. If the dependent's last name is different from your own, please attach explanation

PART C – YOUR DELTA DENTAL OF MN MEMBERSHIP CHOICES

<input type="checkbox"/> Elect: Standard Plan _____ Single _____ Family	<input type="checkbox"/> Terminate Coverage
<input type="checkbox"/> Elect: Standard + Ortho _____ Family only	<input type="checkbox"/> Waive

Benefit Waiver (sign ONLY if declining coverage). I understand that by waiving coverage for **myself and/or my dependents** I cannot elect to participate until next year unless I experience a status change in accordance with the IRS section 125 and submit the change within 30 days of the status change. Delta Dental reserves the right to decline any further enrollment changes.

Employee Signature: _____ Date: _____

PART D – OTHER INSURANCE/MEDICARE COVERAGE (If does not apply skip to PART E)

Do you (employee) have any other dental coverage? Yes Name of Insurance Co: _____

Do your dependents have other dental coverage? Yes Name of Individual with Coverage: _____

Policy/ID No: _____

PART E – AUTHORIZATION OF COVERAGE

I hereby enroll for coverage. I authorize my employer to deduct my premiums before taxes are calculated (premium conversion). Employees will automatically be enrolled in this portion of the Section 125 plan. I understand that I cannot make change or revoke my election for one plan year unless I experience a status change in accordance with the IRS Section 125 and submit the change within 30 days of the status change. You may opt out of the before tax deduction by checking here: By checking this box, I am requesting after tax deductions.

Employee Signature _____ Date _____

GROUP ENROLLMENT INFORMATION – THIS PORTION TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> New Hire Start Date _____ Effective Date _____	<input type="checkbox"/> Qualifying Event <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Change in employment status <input type="checkbox"/> Termination/Voluntary Resignation <input type="checkbox"/> Other (Details) _____	Date Event Occurred: _____ Effective Date of Coverage: _____ End Coverage Effective: _____
Group Name Concordia College Office of Human Resources, 901 8 th St S, Moorhead, MN 56562		Delta Dental MN Group: 50814
Group Representative's Signature		Date: _____ Phone Number: (218) 299-3339

Delta Dental Plan of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis, MN 55440-0330

**HUMAN
RESOURCES**

CONCORDIA COLLEGE
MOORHEAD MN

**Dental
Enrollment Form**