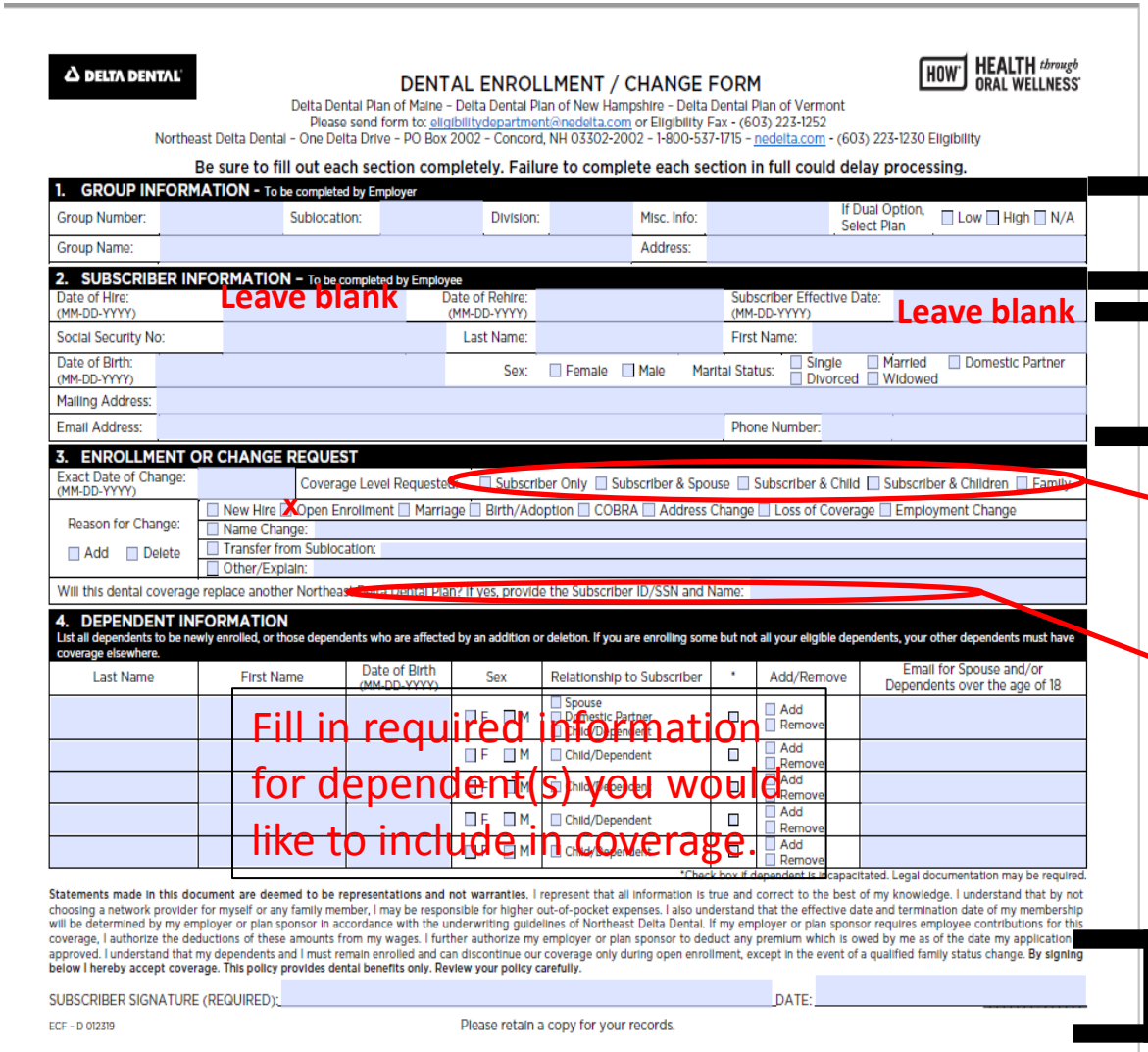

DELTA DENTAL

DENTAL ENROLLMENT / CHANGE FORM

HOW HEALTH through ORAL WELLNESS

Delta Dental Plan of Maine - Delta Dental Plan of New Hampshire - Delta Dental Plan of Vermont
Please send form to: eligibilitydepartment@nedelta.com or Eligibility Fax - (603) 223-1252
Northeast Delta Dental - One Delta Drive - PO Box 2002 - Concord, NH 03302-2002 - 1-800-537-1715 - nedelta.com - (603) 223-1230 Eligibility

Be sure to fill out each section completely. Failure to complete each section in full could delay processing.

1. GROUP INFORMATION - To be completed by Employer

Group Number: | Sublocation: | Division: | Misc. Info: | If Dual Option, Select Plan ☐ Low ☐ High ☐ N/A
Group Name: | Address:

2. SUBSCRIBER INFORMATION - To be completed by Employee

Date of Hire: (MM-DD-YYYY) Leave blank | Date of Rehire: (MM-DD-YYYY) | Subscriber Effective Date: (MM-DD-YYYY) Leave blank
Social Security No: | Last Name: | First Name:
Date of Birth: (MM-DD-YYYY) | Sex: ☐ Female ☐ Male | Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed
Mailing Address:
Email Address: | Phone Number:

3. ENROLLMENT OR CHANGE REQUEST

Exact Date of Change: (MM-DD-YYYY) | Coverage Level Requested: ☐ Subscriber Only ☐ Subscriber & Spouse ☐ Subscriber & Child ☐ Subscriber & Children ☐ Family

Reason for Change: ☐ Add ☐ Delete
☐ New Hire ☒ Open Enrollment ☐ Marriage ☐ Birth/Adoption ☐ COBRA ☐ Address Change ☐ Loss of Coverage ☐ Employment Change
☐ Name Change:
☐ Transfer from Sublocation:
☐ Other/Explain:

Will this dental coverage replace another Northeast Dental Plan? If yes, provide the Subscriber ID/SSN and Name:

4. DEPENDENT INFORMATION

List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion. If you are enrolling some but not all your eligible dependents, your other dependents must have coverage elsewhere.

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Sex	Relationship to Subscriber	*	Add/Remove	Email for Spouse and/or Dependents over the age of 18
			☐ F ☐ M	☐ Spouse ☐ Domestic Partner ☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	

*Check box if dependent is incapacitated. Legal documentation may be required.

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider 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 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. **By signing below I hereby accept coverage. This policy provides dental benefits only. Review your policy carefully.**

SUBSCRIBER SIGNATURE (REQUIRED): _____ DATE: _____

ECF - D 012319

Please retain a copy for your records.

Fill in required information for dependent(s) you would like to include in coverage.

SPSD Section– leave blank

Fill in required personal information.

What level of coverage do you have?

Answer if appropriate

Sign and date.

South Portland School Department

PREMIUM ONLY FLEXIBLE BENEFITS PLAN

ELECTION FORM AND SALARY REDUCTION AGREEMENT

I ,_____, have been informed of my right to participate in the South Portland School Department Premium Only Flexible Benefits Plan (the "Plan").

With respect to Plan benefits for the period July 1, 2019 through June 30, 2020, I hereby make the following elections, pursuant to Article IV of the Plan:

[ ] A. I have enrolled for medical benefit coverage. I elect to receive my medical coverage under the South Portland School Department Premium Only Flexible Benefits Plan. Any previous election and compensation reduction agreement under the Flexible Benefits Plan relating to the same benefits is hereby revoked. I authorize the Employer to make aggregate payroll deductions in the amount of my required contributions for the benefit option I have elected under the Flexible Benefits Plan, in equal installments.

[ ] B. I have enrolled for dental benefit coverage. I elect to receive my dental coverage under the South Portland School Department Premium Only Flexible Benefits Plan. Any previous election and compensation reduction agreement under the Flexible Benefits Plan relating to the same benefits is hereby revoked. I authorize the Employer to make aggregate payroll deductions for the benefit option I have elected under the Flexible Benefits Plan, in equal installments.

[ ] C. I do not elect to participate in the Plan at this time and thus no payroll deductions for the above purposes shall be made.

I recognize that the above election(s) is (are) *irrevocable* for the period stated above (except as may be allowed by IRS regulations) and that I will not be entitled to receive any nonelective portion of the amount(s) specified above as cash compensation.

Dated _____ Signature _____

OFFICE USE ONLY

CIRCLE ONE:
INITIAL ELECTION NEW EMPLOYEE FAMILY STATUS CHANGE

DESCRIBE THE FAMILY STATUS CHANGE:_____
DATE OF FAMILY STATUS CHANGE:_____
DATE RECEIVED:_____
RECEIVED BY:_____

FBP
PREMELE2001.DOC

You must return your enrollment form with a salary reduction agreement as shown to the left. If you would like your dental insurance premiums removed from your pay check before taxes are removed (the most popular option) check box B. If you would like to pay taxes on the dental insurance premiums being removed from your pay, select option C. Date and sign.