



**VERMONT STATE EMPLOYEES ASSOCIATION  
SUPPLEMENTAL DENTAL PROGRAM ENROLLMENT/CHANGE FORM**

Please send form to:  
Vermont State Employees  
Association Supplemental  
Dental Program  
155 State Street  
Montpelier, VT 05602

Delta Dental Plan of Vermont

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

PLEASE SEE INSTRUCTIONS ON REVERSE

**1. SUBSCRIBER INFORMATION - To be completed by VSEA Member or staff**

LAST NAME (SUBSCRIBER)		FIRST NAME		SOCIAL SECURITY / I.D. # — —		GENDER <input type="checkbox"/> M <input type="checkbox"/> F		DATE OF BIRTH (MM-DD-YYYY) — —		
MAILING ADDRESS				CITY		STATE	ZIP		TELEPHONE NO. (HOME) ( )	
EMAIL ADDRESS (HOME)								TELEPHONE NO. (WORK) ( )		
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 VSEA Member or staff**

GROUP NAME Vermont State Employees Association Supplemental Dental Plan		STREET ADDRESS, CITY, STATE, ZIP Vermont State Employees Association Supplemental Dental Program 155 State Street, Montpelier, VT 05602								
GROUP NUMBER <b>7674</b>		DENTAL EFFECTIVE DATE (MM-DD-YYYY)    — —								
SUBLOCATION NUMBER <b>1000</b>		DATE OF HIRE (MM-DD-YYYY)    — —				DATE OF REHIRE (MM-DD-YYYY)    — —				

**3. REASON FOR SUBMISSION - Check all appropriate boxes**

EXACT DATE OF STATUS CHANGE: _____ (MM-DD-YYYY)		<b>MISCELLANEOUS CHANGE:</b>													
<b>ADD:</b>		<b>DELETE:</b>		<input type="checkbox"/> Name change – Previous name: _____											
<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Annual Open Enrollment		<input type="checkbox"/> Transfer from sublocation _____											
<input type="checkbox"/> Annual Open Enrollment		<input type="checkbox"/> Spouse's employment change		<input type="checkbox"/> Address change											
<input type="checkbox"/> COBRA Due to: _____		<input type="checkbox"/> Full-time to part-time status		<input type="checkbox"/> Other _____											
<input type="checkbox"/> Marriage		<input type="checkbox"/> Divorce		<b>COVERAGE LEVEL REQUESTED***:</b>											
<input type="checkbox"/> Birth <input type="checkbox"/> Age Two		<input type="checkbox"/> Deceased									<input type="checkbox"/> Employee (only)		<input type="checkbox"/> Employee/Children		
<input type="checkbox"/> Adoption*		<input type="checkbox"/> No longer eligible for IRS purposes									<input type="checkbox"/> Employee/Spouse		<input type="checkbox"/> Employee/Family		
<input type="checkbox"/> Spouse's employment change		<input type="checkbox"/> Retirement									<input type="checkbox"/> Employee/Child		<input type="checkbox"/> Other _____		
<input type="checkbox"/> Part-time to full-time status***		<input type="checkbox"/> Other													

**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. Coverage level and dependent information are to be the same as are on your Vermont State Employee Dental Assistance Plan through your employer.**

LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	GENDER M/F	RELATION TO SUBSCRIBER	ADD / DELETE	CHECK IF DEPENDENT IS INCAPACITATED*

\*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?     Yes     No  
Will this dental coverage replace another Northeast Delta Dental Plan?     Yes     No    **If yes to either question, complete the following:**

VT STATE EMPLOYEES DENTAL ASSISTANCE PROGRAM Membership in this plan through your employer is a requirement to join the supplemental plan.	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY) — —
DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY) — —
DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY) — —

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 plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my plan sponsor requires VSEA Member contributions for this coverage, I authorize the deductions of these amounts from my salary payments. I further authorize my plan sponsor to deduct any dental premium which is owed by me as of the date my application is approved.

\*\*\*Coverage level and dependent information are to be the same as are on your Vermont State Employee Dental Assistance Plan through your employer.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## Vermont State Employees Association Supplemental Dental Program Instructions for Completing the Northeast Delta Dental Enrollment / Change Form

This plan is designed to supplement the Vermont State Employees Dental Assistance Program through your employer. Therefore, membership in your employer's dental plan is a requirement to join and remain in this Supplemental Program. Enrollment in this plan for yourself and your dependents must be the same as your enrollment in the Vermont State Employee Dental Assistance Program through your employer.

### Section 1. Subscriber Information

This information pertains to the VSEA Member or staff. Please complete all items.

### Section 2. Group Information

Please complete the items entitled

- Dental Effective Date
- Date of Hire or Rehire

### Section 3. Reason for Submission

Please complete

- Items that pertain to your situation
- Coverage Level Requested. Please select only one item in this area. The selected Coverage Level must match the level you have on your Vermont State Employee Dental Assistance Plan through your employer.

### Section 4. Dependent Information

Please complete this section to add eligible or delete ineligible dependents. **Please remember, this program is to include the same dependents as are on your Vermont State Employee Dental Assistance Plan through your employer.** See below for definition of Eligible Persons/Dependents.

### Section 5. Other Group Coverage (Coordination of Benefits)

Please complete this section. It is important to provide your identification number for the Vermont State Employee Dental Assistance Plan.

### Signature and Date

Please sign and date your Enrollment / Change Form prior to mailing.

### Mail the Enrollment / Change form to

Vermont State Employees Association Supplemental Dental Program  
155 State Street  
Montpelier, Vermont 05602

Eligible Persons/Dependents –VSEA Members or staff who have been employed by the State of Vermont in a benefit-eligible position for at least seven months and are covered by the State of Vermont plan, #7161, spouses, partners to a civil union, domestic partners of subscribers and eligible dependents may be enrolled. Children may be covered until age 26. In all cases, Northeast Delta Dental will provide Coverage for newborn children for the first thirty-one (31) days following birth at no additional premium. Upon receipt of an enrollment form for a new child, coverage will resume on the first day of the month following birth.

VSEA members or staff may add a newly acquired dependent on the first of the month following a qualifying event, such as a marriage, birth or adoption of a new child if the dependent is also added to your Vermont State Employee Dental Assistance Plan membership through your employer. Contact the Vermont State Employees Association for a form to add the new dependent. The form must be returned to the Association along with proof of the qualifying event, i.e., marriage certificate, birth certificate, or adoption papers.

If the Enrollment Form is incomplete, it will be returned to you by the Vermont State Employees Association office.