DELTA DENTAL

Delta Dental Plan of Vermont

VERMONT STATE EMPLOYEES ASSOCIATION

SUPPLEMENTAL DENTAL PROGRAM ENROLLMENT/CHANGE FORM

PLEASE SEE INSTRUCTIONS ON REVERSE

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

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

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

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. #	GENDER	DATE OF BIRTH (MM-DD-YYYY)
		— —	☐ M ☐ F	— —

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO. (HOME)
				( )

EMAIL ADDRESS	TELEPHONE NO. (WORK)
	( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER _____

2. GROUP INFORMATION - To be completed by VSEA Member or staff

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

ADD:

- ☐ **New Enrollment**
- ☐ Annual Open Enrollment
- ☐ COBRA Due to: _____
- ☐ Marriage
- ☐ Birth ☐ Age Two
- ☐ Adoption*
- ☐ Spouse's employment change
- ☐ Part-time to full-time status***

DELETE:

- ☐ Annual Open Enrollment
- ☐ Spouse's employment change
- ☐ Full-time to part-time status
- ☐ Divorce
- ☐ Deceased
- ☐ No longer eligible for IRS purposes
- ☐ Retirement
- ☐ Other

MISCELLANEOUS CHANGE:

- ☐ Name change – Previous name: _____
- ☐ Transfer from sublocation _____
- ☐ Address change
- ☐ Other _____

COVERAGE LEVEL REQUESTED***:

- ☐ Employee (only)
- ☐ Employee/Children
- ☐ Employee/Spouse
- ☐ Employee/Family
- ☐ Employee/Child
- ☐ 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)

Enrollment in State of Vermont Employee Dental Assistance Program is a requirement to join the Supplemental Plan.
Please list the subscriber ID number and Effective Date of the Vermont Employee Dental Assistance Plan.

VT STATE EMPLOYEES DENTAL ASSISTANCE PROGRAM Membership in this plan through your employer is a requirement to join the supplemental plan.	SUBSCRIBER ID # 330000 _ _ _ _ _ _ _ _	EFFECTIVE DATE (MM-DD-YYYY) — —

Will you, your spouse, or any dependent be covered by any other dental plan while this policy is in effect? ☐ Yes ☐ No
If yes, complete the following:

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 _____