BlueCross BlueShield of Minnesota | DELTA DENTAL

Loc #

ENROLLMENT / CHANGE / WAIVE GROUP COVERAGE FORM

- **If waving coverage, sign "Wavier of Coverage" in Section E**
- **If enrolling or changing coverage, complete form**

Location________________________

A. EMPLOYEE INFORMATION

Employee's Last Name	First Name	M.I.	Social Security Number	Home Phone

Employee's Home Address	Street	City	State	Zip Code	Work Phone

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED – CHANGE or COMPLETE ALL THAT APPLY (USE EXTRA PAPER IF NECESSARY)

Relation	Last Name First Name M.I	Add / Cancel	Sex	Marital Status	Social Security #	Birth Date (Mo.Day Yr.)
Self		☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Spouse		☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Child/ Stepchild		☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Child/ Stepchild		☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Child/ Stepchild		☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		

C. BENEFIT SELECTION – CHECK APPROPRIATE BOXES TO ADD OR CHANGE COVERAGE

Coverage Selected: ☐ Single ☐ Family Coverage Level: ☐ $1000 Deductible ☐ $6350 Deductible

D. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and Part B (Medical)? Yes (complete section below):

Employee: Effective Date Part A [ ] [ ] [ ] Effective Date Part B [ ] [ ] [ ] Medicare Claim Number [ ]

Eligibility reason for Medicare: ☐Age ☐Disability ☐End-Stage Renal Disease ☐Disability & End-Stage Renal Disease

Spouse: Effective Date Part A [ ] [ ] [ ] Effective Date Part B [ ] [ ] [ ] Medicare Claim Number [ ]

Eligibility reason for Medicare: ☐Age ☐Disability ☐End-Stage Renal Disease ☐Disability & End-Stage Renal Disease

E. SIGNATURE

AUTHORIZATION OF COVERAGE

MY SIGNATURE AUTHORIZES ANY PAYROLL DEDUCTION REQUIRED TO PARTICIPATE IN THE PLAN. I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X

Month	Date	Year

Signature of Employee **Date Signed**

WAIVER OF COVERAGE

I HAVE BEEN INFORMED THAT I AM ELIGIBLE FOR COVERAGE THROUGH MY EMPLOYER. I DO NOT WANT COVERAGE.

X

Month	Date	Year

Signature of Employee **Date Signed**

PLEASE UPLOAD CHANGED OR WAIVED ENROLLMENT FORMS TO DROPBOX

Diocese of Winona ☐ Uploaded to Dropbox
PO Box 588 OR Fax: OR E-mail:
Winona, MN 55987 (507)454-8106 benefits@dow.org
Questions? Contact the Employee Benefits Coordinator at (507) 858-1268 or benefits@dow.org

DOW Office Use: Group Numbers: Health:___________________ Dental: ___________________
Department: _________ Start Date: ___________________ Effective Date: ___________________