



# Group Dental Plan(s) for St. Louis County & Affiliated Employers



## Required Information

Name		Birth Date	Gender	Active Employee # _____	Social Security Number _____
First: _____		_____	_____	Retiree/Retiree Spouse	
Middle: _____				Surviving Spouse	
Last: _____		<input type="checkbox"/> Check if this is a name change & write former name here: _____			(Required for coverage)
Employee/Retiree's Address				Home/Cell Phone: _____	
Street Address: _____				Work Phone: _____	
City: _____ State: _____ Zip: _____				Email: _____	
<input type="checkbox"/> Check if this is a new address					
Married?:		Yes; Either waive/drop coverage for spouse below or complete:		Date of Marriage: _____	
No		Location of marriage (County & State): _____			

## Add, Change or Waive Coverage

Employee/Retiree	Effective Date _____ to _____	Add	Drop	Waive	Move subgroups
Spouse	Effective Date _____ to _____	Add	Drop	Waive	Move subgroups
Children	Effective Date _____ to _____	Add	Drop	Waive	Move subgroups

Effective Dates:

- **New spouse or child:** effective on the date of marriage/birth/adoption
- **Retirement and divorce:** effective the first of the month following the event date
- **Open enrollment:** effective on January 1<sup>st</sup> of the following year
- **New Employee:** effective the first of the month following six full calendar months or 1,000 hours worked
- **Loss of other health coverage:** effective the first of the month following loss of other coverage

## Check ALL that apply: (two or more dependents = family coverage)

Date of recent/upcoming event below: \_\_\_\_\_

<input type="checkbox"/> New Employee, Hire date: _____	<input type="checkbox"/> Marriage;
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Birth/Adoption; County & State: _____
<input type="checkbox"/> Rehire/LOA, Return date: _____	_____
<input type="checkbox"/> Change coverage from spouse only plan to family plan	<input type="checkbox"/> Death
<input type="checkbox"/> Change coverage from spouse only plan to 1Child plan	<input type="checkbox"/> Name or Address Change
<input type="checkbox"/> Change coverage from 1Child plan to Spouse only plan	<input type="checkbox"/> Retirement
<input type="checkbox"/> Change coverage from 1Child plan to family plan	<input type="checkbox"/> Loss of other coverage
<input type="checkbox"/> Change coverage from family plan to Spouse only plan	<input type="checkbox"/> Divorce/legal separation
<input type="checkbox"/> Change coverage from family plan to 1Child plan	Ex-spouse address: _____
<input type="checkbox"/> Other: _____	_____
_____	_____

**Dependents (two or more dependents = family coverage)**

Add/Drop (circle one)	Name (first/middle/last)	Social Security Number	Gender (M/F)	Birth Date (mm/dd/yyyy)	Relation to Applicant Spouse, Child, Stepchild, Grandchild, etc.
Add Drop					

**Dual Coverage/Prior Coverage (skip this section if you are only dropping coverage)**

Name of policyholder	Name & phone number of Insurance company	Subscriber Number	Type of Coverage	Coverage Start Date	Coverage End Date	Reason Coverage Ended

**Authorization**

I hereby apply for coverage for which I am or may become eligible for under the group contract(s) issued by my employer. I also authorize my employer to deduct from my pay any contributions that may be required for the cost of enrolled coverage. I reserve the right to revoke this deduction authorization at any time on written notice to my employer.

By signing this form, I certify that the information provided in this application is true and correct. I further understand that should any of my dependents at any time not meet the health coverage eligibility requirements, whether due to divorce or other reasons, I will inform either the County Employee Relations Department or the health insurance carrier Blue Cross/Blue Shield of Minnesota within 30 days of the event which results in the loss of eligibility. I understand that St. Louis County may periodically ask for substantiation of dependent status, and that claims paid for ineligible dependents may be retroactively denied.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

After completing and signing, submit this form to:

**To be completed by Employer:**

Employer Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Group Rep Name \_\_\_\_\_ Phone \_\_\_\_\_

**To be processed by BCBS staff only:**  
 Effective date: \_\_\_\_\_  
 Prior Group # \_\_\_\_\_  
 New Group # \_\_\_\_\_  
 Prior dental enrollment:   Single   None  
 New dental enrollment:   Single   None

**To be processed by Delta Dental staff only:**  
 Effective date: \_\_\_\_\_  
 Prior Group # \_\_\_\_\_  
 New Group # \_\_\_\_\_  
 Prior enrollment:   Spouse   1 child   Family   None  
 New enrollment:   Spouse   1 child   Family   None

Auditor's Office – Payroll Division  
 St. Louis County Court House  
 100 N. 5<sup>th</sup> Ave West Room 201  
 Duluth, MN 55802

Notes:  
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