

Dependents (when reporting a name change, drop old name and add new name)

Add/Drop (circle one)	Name (first/middle/last)	Gender (M/F)	Birth Date (mm/dd/yyyy)	Relation to Applicant Spouse, Child, Stepchild, Grandchild, etc.
<input type="checkbox"/> Add <input type="checkbox"/> Drop				
<input type="checkbox"/> Add <input type="checkbox"/> Drop				
<input type="checkbox"/> Add <input type="checkbox"/> Drop				
<input type="checkbox"/> Add <input type="checkbox"/> Drop				
<input type="checkbox"/> Add <input type="checkbox"/> Drop				
<input type="checkbox"/> Add <input type="checkbox"/> Drop				

Social Security Numbers are used by Delta Dental to distinguish between enrollees. Failure to provide the employee's social security number upon application for coverage will result in Delta Dental denying you coverage. Dependent Social Security numbers are not required. See the employee dental plan's full privacy notice at www.stlouiscountymn.gov/benefits or by requesting it at 218-726-2422.

Dual Coverage or 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

By signing this form, I certify that the information provided in this application is true and correct. I also authorize my employer to deduct from my pay any contributions that may be required for the cost of enrolled coverage. I further understand that should any of my dependents at any time not meet the eligibility requirements, whether due to divorce or other reasons, I will inform the County Human Resources Department 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:

Auditor's Office – Payroll Division
St. Louis County Court House
100 N. 5th Ave West Room 201
Duluth, MN 55802 OR
benefitforms@stlouiscountymn.gov
from internal email only

To be completed by Employer:

Employer Signature _____ Date _____

Effective date: _____

Prior Group # _____

New Group # _____

Prior dental enrollment: Single None

New dental enrollment: Single None

Effective date: _____

Prior Group # _____

New Group # _____

Prior enrollment: Spouse 1 child Family None

New enrollment: Spouse 1 child Family None

Notes:

