DELTA DENTAL®

Delta Dental of Rhode Island
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ENROLLMENT FORM

GROUP INFORMATION

HR WILL COMPLETE THIS, SKIP AHEAD TO SUBSCRIBER INFORMATION

Employer / Group Name RWU Group No. 7285 Division Name (select from dropdown)

I. SUBSCRIBER INFORMATION

Subscriber Name | Date of Birth (MM/DD/YYYY) | EMPLOYEE ID#

Street Address / P.O. Box No. | Apt. No | City | State | Zip

Email Address | Date of Hire | Phone

2. ENROLLMENT INFORMATION

Effective Date MM/DD/YYYY

Benefits are effective the first of the month after your hire date or the date of a qualifying event (except birth/adoption). Open Enrollment changes are effective July 1st.

Reason for Form: ☐ New Hire/Re-Hire ☐ Open Enrollment ☐ Qualifying Event - *Be sure to include required documentation.*

Coverage Type: ☐ **INDIVIDUAL** ☐ **FAMILY**

3. DEPENDENT INFORMATION

FIRST NAME	LAST Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship

4. COORDINATION OF BENEFITS - Other Coverage

Are you or any of your dependents covered by another DENTAL plan, as of the effective date of this coverage?

☐ No ☐ Yes *If Yes, please complete the section below.*

Policyholder Name (First, Last) | Policyholder I.D. No. | Group I.D. No.

Dental Insurance Company | Dental Insurance Address (Street, City, State, Zip)

Employer Name *(through which you/your dependents have coverage)*

5. CERTIFICATION & SIGNATURE

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. If my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature | Date | Benefits Administrator Authorization | Date

Revised 3/2025

SUBMIT TO Human Resources