DELTA DENTAL®

VERMONT RETIREMENT SYSTEMS ENROLLMENT FORM

Delta Dental Plan of Maine
Delta Dental Plan of New Hampshire
Delta Dental Plan of Vermont

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 Retirement Systems
109 State Street, 4th Floor
Montpelier, VT 05609-6901

1. SUBSCRIBER INFORMATION - To be completed by Retiree

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

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

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

EMAIL

2. GROUP INFORMATION - To be completed by Retiree

Group Name and Number – Check the Group Name and Plan that apply.

☐ Vermont State Employees' Retirement System, Group Number 7629: ☐ Plan A (1000) ☐ Plan B (1001)
☐ Vermont State Teachers' Retirement System, Group Number 7657: ☐ Plan A (1000) ☐ Plan B (1001)
☐ Vermont State Municipal Employees Retirement System, Group Number 7755: ☐ Plan A (1000) ☐ Plan B (1001)

STREET ADDRESS, CITY, STATE, ZIP

Vermont Retirement Systems
109 State Street, 4th Floor
Montpelier, Vermont 05609-6901

DENTAL EFFECTIVE DATE

3. REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: _____

ADD:

☐ **New Enrollment**
☐ COBRA Due to: _____
☐ Marriage
☐ Birth ☐ Age Two
☐ Adoption*
☐ Spouse's employment change

DELETE:

☐ Spouse's employment change
☐ Divorce
☐ Deceased
☐ No longer dependent for IRS purposes
☐ Cancel coverage

MISCELLANEOUS CHANGE:

☐ Name change – Previous name: _____
☐ 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. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

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)

Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? ☐ Yes ☐ No
Will this dental coverage replace another Northeast Delta Dental Plan? ☐ Yes ☐ No

If yes to either question, complete the following:

DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE
DENTAL INSURANCE COMPANY	**POLICY HOLDER ID # / SOCIAL SECURITY #**	**EFFECTIVE DATE**

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 retiree contributions for this coverage, I authorize the deductions of these amounts from my pension 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.

SIGNATURE _____ DATE _____

Vermont Retirement Systems
Instructions for Completing the Northeast Delta Dental Enrollment / Change Form

Section 1. Subscriber Information
-This information pertains to the retiree. Please complete all items.

Section 2. Group Information
-Please check the group you wish to join
-Check Plan A or Plan B as your choice of coverage
-Complete Dental Effective Date

Section 3. Reason for Submission
-Please complete items that pertain to your situation

Section 4. Dependent Information
-Please complete this section to add eligible or delete ineligible dependents. -
-See below for definition of Eligible Persons/Dependents.

Section.5. Other Group Coverage (Coordination of Benefits)
-Please complete this section.

Signature and Date
-Please sign and date your Enrollment / Change Form prior to mailing.

Mail the Enrollment / Change form to:
Vermont Retirement Systems
109 State Street, 4th Floor
Montpelier, Vermont 05609-6901

Eligible Persons/Dependents - Retirees, spouses, partners of a civil union, domestic partners of subscribers who are such at the time of the subscriber's initial enrollment in the plan, surviving dependent beneficiaries,and eligible dependents may be enrolled. Children may be covered until their 26th birthday. If enrolling dependents, all eligible dependents must be enrolled unless they are covered elsewhere. In all cases, Delta Dental will provide Coverage for newborn children for the first thirty-one (31) days following birth at no additional premium. Coverage will continue if the child is formally enrolled by returning an enrollment form to the Retirement Division within the first sixty (60) days following birth, or the child may be enrolled the first of the month following the child's first birthday.

Retirees may add a newly acquired dependent on the first of the month following a qualifying event, such as a marriage, birth, or adoption of a new child. The enrollment/change form to add the new dependent, which must be returned to the Retirement Division along with proof of the qualifying event, i.e., marriage certificate, birth certificate, or adoption papers.