

# **Dental Membership Maintenance Form**

Anthem

Dental Enrollment Department PO Box 1193 Minneanolis MN 55440-1193

Spouse  Dependent Child  Dependent Child  Dependent Child  Dependent Child  Dependent Child  M F Y N Y N  Dependent Child  M F Y N Y N  N  PART D – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change  Qualifying Event Number:  1 Termination or Reduction of Work Hours  2 Employee Death  4 Divorce/Legal Separation  Event Number  Date of Event  Social Security Number  Employee & All Dependents Currently Enrolled  Employee Only  Spouse Only	PART A - EMPLOYEE INFORMATION	Millileapolis	WIN 55440-1195		INCTO	LICTIONS DE	OVIDED	ONBA	CK							
Employee's Name: Gender: Male Female Marital Single Marited Widowed Divorced Legally Separated Date of Birth (Month-Day-Year)  Employee's Address: Glay Status:  Clay Code  Date of Event Code next to correct Coverage Type and complete Part C if Adding or Dropping Dependents May Require a Coverage Type Dependent No Longer Eligible  Clay Status:  Clay Status:  Clay Status:  Clay Code  Date of Event Clading or Dropping Dependents May Require a Coverage Type  Employee & Dependent Child (ren)  Employee & Dependent Child Initial, Last Name  Clay Status:  Clay Status:  Clay Code  Date of Change:  Clay Cod	Employee's Name:    Condender: Maine   Fermille   Marital   Social Security Number   Sance:   Check if   Status:	PART A -	EMPLOYEE INF	ORMATIO		OCTIONS PA	CONDED	ON BA	icn							
Name:   Status:   Status:   Date of Birth (Month-Day-Year)	Name:	Last First						Middle Initial				Social Security Number				
Gender: Male   Female   Marital   Status:	Gender: Male   Fernine   Status:											•				
Status:	Status:		lale Female Ma	rital Single	Married	Widowed	Divorced	Legally Se	Legally Separated		Date of Birth (Month-Day-Vear)					
Employee's   Address   City   State   Address   City   State   Apply - Provide Information Requested By Category   Name Change   Terminate Employee and All Dependent Coverage   Date of Termination:   Date Coverage Ends.   Date Of Coverage Type and complete Part Cif Adding or Dropping Dependents Qualifying Event Code next to correct Coverage Type and complete Part Cif Adding or Dropping Dependents Qualifying Event Code Coverage Type Employee Employee Only   Employee Only   Employee Request Category   Date of Event   Effective Date of Change   Employee Coverage M - Marriage O - Group Open Enrollment S - Dependent No Longer Eligible   Employee & Spouse   Employee & Spouse   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Effective Date of Change   Employee & Date Of Event   Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change   Employee & Date Of Event   Event Number   Date of Event   Social Security Number   Employee & Date Only   Employee & Date Only   Event Number   Date of Event   Social Security Number   Employee & Date Only   Event Number   Date Only   Event Number   Date Only   Event Number   Date	Mork Proces Number   Address   Home Proce Number   Work Proces Number   Address   City   State   Zip Code						П	П			J U	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		. Day	. ou.,	
Address:   Check If   Check If   Check If   Check All Categories That Apply – Provide Information Requested By Category   Change   Check All Categories That Apply – Provide Information Requested By Category   Change   Change   Check All Categories That Apply – Provide Information Requested By Category   Change   Chan	Address   Check If   Check If   Check If   Check All Categories That Apply – Provide Information Requested By Category   Date of Terminate Employee and All Dependent Coverage   Date of Terminate Employee and All Dependent Coverage   Date of Termination:   Date Coverage Ends:   Date of Change:   Change Employee Group/Subgroup (Move individual to different group/subgroup number, including COBRA subgroup) From:   To:   Effective Date of Change:   Change Coverage Type Due to Qualifying Event – List Qualifying Event Code next to correct Coverage Type and complete Part C if Adding or Dropping Dependents Qualifying Event Code:   A – Adoption B – Birth D – Divorce/Legal Separation E – Death L – Loss of Coverage M – Marriage O – Group Open Enrollment S – Dependent No Longer   Eligible   Employee & Dependent Child(ren)   Employee & Dependent Child(ren)   Employee & Dependent Child(ren)   Employee & Dependent Child(ren)   Family   PART C – DEPENDENT INFORMATION – Adding or Dropping Dependents May Require a Coverage Type   First Name, Middle Initial, Last Name   Gender   Date of Birth   Student?   Unmarried?   Spouse   M   F   Full Time   Student?   Unmarried?   N   PART D – COBRA – Employee Note: Complete Only   Employee Death   Dependent Child   M   F   Y   N   Y   N   PART D – COBRA – Employee Note: Complete Only   Employee Separation   Separ	Employee				<u></u>		Н	ome Phor	ne Number		Wo	rk Phone	e Number		
New Address	New Address															
Name Change	PART B - CHANGE REQUEST - Check All Categories That Apply - Provide Information Requested By Category   Name Change   Terminate Employee and All Dependent Coverage   Date of Termination:   Date of Termination:   Date of Termination:   Date Coverage Ends:   Date of Change   Sembloyee Group/Subgroup (Move individual to different group/subgroup number, including COBRA subgroup) From:   To: Effective Date of Change:   Employee Colly   Employee Spouse   Employee Colly   Employee Spouse   Employee Spous	☐ Checl	k If City		State	9		Zip	Code							
Name Change	Name Change															
Pormer Name:	Former Name: New Name: Date of Termination: Date Coverage Ends:    Change Employee Group/Subgroup (Move individual to different group/subgroup number, including COBRA subgroup) From: To: Effective Date of Change:   Change Coverage Type Due to Qualifying Event — List Qualifying Event Code: A — Adoption B — Birth D — Divorce/Legal Separation E — Death L — Loss of Coverage M — Marriage O — Group Open Enrollment S — Dependent No Longer Eligible   Qualifying Event Code															
New Name:	New Name:	<del></del>	•													
Change Employee Group/Subgroup (Move individual to different group/subgroup number, including COBRA subgroup) From: To: Effective Date of Change:  □ Change Coverage Type Due to Qualifying Event — List Qualifying Event Code next to correct Coverage Type and complete Part C if Adding or Dropping Dependents Qualifying Event Code: A – Adoption B – Birth D – Divorce/Legal Separation E – Death L – Loss of Coverage M – Marriage O – Group Open Enrollment S – Dependent No Longer Eligible  Qualifying Event Code  □ Coverage Type Change Request Category	Change Employee Group/Subgroup (Move individual to different group/subgroup number, including COBRA subgroup) From: To: Effective Date of Change:    Change Coverage Type Due to Qualifying Event − List Qualifying Event Code next to correct Coverage Type and complete Part C if Adding or Dropping Dependents Qualifying Event Code: A − Adoption B − Birth D − Divorce/Legal Separation E − Death L − Loss of Coverage M − Marriage O − Group Open Enrollment S − Dependent No Longer Eligible    Qualifying Event Code															
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Eligible  Qualifying Event Code   Coverage Type Change Request Category   Date of Event   Effective Date of Change	Eligible  Qualifying Event Code   Coverage Type Change Request Category   Date of Event   Effective Date of Change														egal	
Employee & Spouse  Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type Relationship To Employee Spouse  Dependent Child Spouse  Dependent Child MF Dependent Child MF Dependent Child MF	Employee Only Employee & Spouse Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type Relationship To Employee Spouse  Dependent Child Spouse  Dependent Child M F Depend			_ – Loss of (	Coverage I	<b>VI</b> – Marriage	<b>O</b> – Grou	p Oper	Enrol	Iment S - I	Depei	ndent	No Lo	onger		
Employee & Spouse  Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type  Relationship To Employee  Spouse  Dependent Child  Date of Event  Social Security Number  Date of Event  Social Security Number	Employee & Spouse  Employee & Spouse  Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type Relationship To Employee Spouse  M F Dependent Child M F	Qualifyir	ng Event Code	Coverage	Type Ch	ange Reque	st Catego	ory	Date	of Event	Eff	ective	Date	of Ch	nange	
Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type  Relationship To Employee Spouse  Dependent Child Spouse  Dependent Child M F Dependent Child Dependent Child Dependent Child Dependent Child Dependent Child Dependent Child Dependent No Longer Eligible  Coverage Continuation Applies To: Dependent Number Date of Event Date of Event Dependent Child Dependents Currently Enrolled	Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type  Relationship To Employee  Spouse  Dependent Child  Dependent	•		Employee	Only											
Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type  Relationship To Employee Spouse  Dependent Child Spouse  Dependent Child M F Dependent Child Dependent Child Dependent Child Dependent Child Dependent Child Dependent Child Dependent No Longer Eligible  Coverage Continuation Applies To: Dependent Number Date of Event Date of Event Dependent Child Dependents Currently Enrolled	Employee & Dependent Child(ren) Family  PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type  Relationship To Employee  Spouse  Dependent Child  Dependent			Employee	& Spouse											
Family   PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type   Relationship To Employee   First Name, Middle Initial, Last Name   Gender   Date of Birth   Student?   Unmarried?   Spouse   M F   Y N Y N Y N   N   Dependent Child   M F   Y N Y N Y N   N   Dependent Child   M F   Y N Y N Y N   N   PART D - COBRA - Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change   Qualifying Event Number: 1 Termination or Reduction of Work Hours 3 Employee Total Disability 5 Employee Eligible for Medicare 2 Employee Death 4 Divorce/Legal Separation 6 Dependent No Longer Eligible   Coverage Continuation Applies To:   Event Number   Date of Event   Social Security Number   Employee Only   Spouse Only   Spouse Only   Spouse Only   Spouse Only   Spouse Only   Spouse Signal Security Number   Spouse Only   Spous	Family   PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type			Employee	& Depend	lent Child(ren	)									
Relationship   First Name, Middle Initial, Last Name   Gender   Date of Birth   Student?   Unmarried?	PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type  Relationship To Employee First Name, Middle Initial, Last Name Gender Date of Birth Student? Unmarried?  Spouse M F Dependent Child M F M F M Y N Y N Y N Dependent Child M F M F M Y N Y N Y N Dependent Child M F M F M Y N Y N Y N Y N Dependent Child M F M F M F M Y N Y N Y N PART D - COBRA - Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change Qualifying Event Number:  1 Termination or Reduction of Work Hours 3 Employee Total Disability 5 Employee Eligible for Medicare 2 Employee Death 4 Divorce/Legal Separation 6 Dependent No Longer Eligible  Coverage Continuation Applies To: Event Number Date of Event Social Security Number Employee & All Dependents Currently Enrolled Employee & Spouse Only  Dependent(s) Only - List Names in Part C  Employee & Dependent Child(ren)-List Names in Part C				•	•										
Add Drop To Employee Spouse M F Student? Unmarried?    Spouse M F	Add Drop       To Employee       Gender       Date of Birth       Student? Unmarried?         Spouse       M       F       F       F       F       F       N       Y	PART C -	DEPENDENT IN	<b>IFORMATIO</b>	ON – Addi	ng or Droppi	ing Depe	ndents	May I	Require a	Cove					
Spouse  Dependent Child  Dependent Child  Dependent Child  Dependent Child  Dependent Child  M F Y N Y N  Dependent Child  M F Y N Y N  N  PART D – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change  Qualifying Event Number:  1 Termination or Reduction of Work Hours  2 Employee Death  4 Divorce/Legal Separation  Event Number  Date of Event  Social Security Number  Employee & All Dependents Currently Enrolled  Employee Only  Spouse Only	Spouse  Dependent Child  Dependent Child  Dependent Child  Dependent Child  Dependent Child  M F Y N Y N  Dependent Child  M F Y N Y N  N  PART D – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change  Qualifying Event Number:  1 Termination or Reduction of Work Hours  2 Employee Death  4 Divorce/Legal Separation  6 Dependent No Longer Eligible  Coverage Continuation Applies To:  Event Number  Date of Event  Social Security Number  Employee & All Dependents Currently Enrolled  Employee Only  Dependent(s) Only – List Names in Part C  Employee & Spouse  Employee & Dependent Child(ren)–List Names in Part C		•	First	Name, Mic	ddle Initial, L	ast Name									
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Dependent Child  M F Y N Y N  PART D – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change  Qualifying Event Number:  1 Termination or Reduction of Work Hours 3 Employee Total Disability 5 Employee Eligible for Medicare  2 Employee Death 4 Divorce/Legal Separation 6 Dependent No Longer Eligible  Coverage Continuation Applies To:  Event Number Date of Event Social Security Number  Employee & All Dependents Currently Enrolled  Employee Only  Spouse Only	Dependent Child  Dependent Child  PART D - COBRA - Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change  Qualifying Event Number:  1 Termination or Reduction of Work Hours 2 Employee Death  4 Divorce/Legal Separation 6 Dependent No Longer Eligible  Coverage Continuation Applies To:  Event Number  Date of Event  Social Security Number  Employee & All Dependents Currently Enrolled  Employee Only  Spouse Only  Dependent(s) Only - List Names in Part C  Employee & Dependent Child(ren)-List Names in Part C		•									+	N		N	
PART D – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change  Qualifying Event Number:  1 Termination or Reduction of Work Hours 3 Employee Total Disability 5 Employee Eligible for Medicare 2 Employee Death 4 Divorce/Legal Separation 6 Dependent No Longer Eligible  Coverage Continuation Applies To: Event Number Date of Event Social Security Number  Employee & All Dependents Currently Enrolled  Employee Only  Spouse Only	PART D – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits and may require subgroup change  Qualifying Event Number:  1 Termination or Reduction of Work Hours 3 Employee Total Disability 5 Employee Eligible for Medicare 2 Employee Death 4 Divorce/Legal Separation 6 Dependent No Longer Eligible  Coverage Continuation Applies To: Event Number Date of Event Social Security Number  Employee & All Dependents Currently Enrolled  Employee Only  Spouse Only  Dependent(s) Only – List Names in Part C  Employee & Spouse  Employee & Dependent Child(ren)–List Names in Part C		Dependent Chil	d				N	l F			Υ	N	Υ	N	
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2 Employee Death 4 Divorce/Legal Separation 6 Dependent No Longer Eligible  Coverage Continuation Applies To: Employee & All Dependents Currently Enrolled Employee Only Spouse Only	2 Employee Death 4 Divorce/Legal Separation Coverage Continuation Applies To: Employee & All Dependents Currently Enrolled Employee Only Spouse Only Dependent(s) Only - List Names in Part C Employee & Dependent Child(ren)-List Names in Part C	Qualifying Event Number:														
Coverage Continuation Applies To:  Event Number  Date of Event Social Security Number  Employee & All Dependents Currently Enrolled Employee Only Spouse Only	Coverage Continuation Applies To:       Event Number       Date of Event       Social Security Number         Employee & All Dependents Currently Enrolled       Image: Continuation Applies To: Continuati															
☐ Employee & All Dependents Currently Enrolled   ☐ Employee Only   ☐ Spouse Only	☐ Employee & All Dependents Currently Enrolled   ☐ Employee Only   ☐ Spouse Only   ☐ Dependent(s) Only – List Names in Part C   ☐ Employee & Spouse   ☐ Employee & Dependent Child(ren)—List Names in Part C	· •														
☐ Employee Only ☐ Spouse Only	☐ Employee Only   ☐ Spouse Only   ☐ Dependent(s) Only – List Names in Part C   ☐ Employee & Spouse   ☐ Employee & Dependent Child(ren)–List Names in Part C				41	_1	Event	lumbei	Dat	e of Event	: 50	ociai	Secur	ity Nu	mber	
☐ Spouse Only	□ Spouse Only   □ Dependent(s) Only – List Names in Part C   □ Employee & Spouse   □ Employee & Dependent Child(ren)–List Names in Part C			ents Currer	itly Enrolle	a										
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Dependent(s) Only – List Names in Part C	☐ Employee & Spouse ☐ Employee & Dependent Child(ren)–List Names in Part C															
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☐ Employee & Spouse		Employ	yee & Spouse													
☐ Employee & Dependent Child(ren)–List Names in Part C	PART E – GROUP INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER	☐ Employ	yee & Dependent	Child(ren)-	List Name	s in Part C	<u> </u>									
PART E – GROUP INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER		PART E -	GROUP INFOR	MATION -	THIS PAR	T TO BE CON	MPLETED	BY EN	/IPLOY	/ER						
	Group Name: Group & Subgroup Numbers:	Group Name:					Group & Subgroup Numbers:									
Group Name: Group & Subgroup Numbers:		Group Representative's Signature:					l	Date: Phone Number: ( )							)	
· · · · · · · · · · · · · · · · · · ·		Group Representative's Signature:					Date: Phone Number: ( )									

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### **Instructions for Completion of Membership Maintenance Form**

### **Important Information:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

### **Important Notes:**

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., first of the month, end of month, or actual dates).
- Before submitting, review it to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned to you and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt by Anthem Dental.

## PART A: EMPLOYEE INFORMATION - Complete all sections.

# PART B: CHANGE REQUEST – Check one or more categories that apply and provide information as requested by category.

- Name Change Provide name as previously reported and new name.
- **Terminate Employee and All Dependents** Only use this section if the employee <u>and</u> all dependent coverage is being terminated.
- Change Employee Group/Subgroup Move employee from one group/subgroup number to another for benefit, reporting or COBRA purposes.
- Coverage Type Change Complete this section to change Coverage Type and to add or drop dependent coverage. Coverage Type change requires a qualifying event (i.e., marriage, divorce, etc.) List Qualifying Event Code on line next to correct Coverage Type. Provide detailed information for each dependent being added or dropped in Part C.

## PART C: DEPENDENT INFORMATION

- List dependents to be added or dropped when making a change to Coverage Type in Part B.
- Complete all sections for each dependent.
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

# PART D: COBRA – Complete this section only if an individual has selected continuation of coverage under COBRA.

- Select a Coverage Type, the appropriate Qualifying Event Number, and Date of Qualifying Event and Effective Date of Coverage.
- If employee is <u>not</u> enrolling for COBRA, provide Social Security Number of individual who is being enrolled.
- If group has a separate COBRA subgroup, it must be provided in Part B.

#### PART E: GROUP INFORMATION - Completed By Employer

- **Group Name** Provide group name as listed in your contract.
- Group and Subgroup Number Provide applicable numbers for individual employee.
- Group Representative Sign, date, and provide your phone number.

# **Send Completed Form To:**

Anthem Attn: Dental Enrollment Department PO Box 1193 Minneapolis MN 55440-1193