Operating Engineers Local #49
Health and Welfare Fund
PO Box 313
Minneapolis, MN 55440-0313
(952) 854-0795 or 1-800-535-6373

Retiree Dental Plan Enrollment Form

Delta Dental of Minnesota

Part A – Retiree Information

Retiree's Name Last / First / Middle Initial		Social Security Number	
Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	Date of Birth (MM/DD/YYYY)	
Retiree's Mailing Address Address		Phone Number	
City		State	Zip Code

Part B – Enrollment Information

Select Coverage Type – Who Is Being Enrolled – Check One Box Only	
☐ Retiree Only ☐ Spouse Only ☐ Dependent Child Only ☐ Retiree + 1 ☐ Family	
Select a Plan Option – Standard Plan/High Plan – Check One Box Only ☐ Standard Plan ☐ High Plan	Effective Date (MM/DD/YYYY)

Part C – Dependent Information (Retiree + 1 and Family Coverage Only)

Relationship to Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different from Retiree's)	Gender		Date of Birth (MM/DD/YYYY)
Spouse		M	F	
Dependent Child		M	F	
Dependent Child		M	F	
Dependent Child		M	F	
Dependent Child		M	F	

☐ I am enrolling myself and my dependents, if applicable.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

Retiree Signature: ______________________________ Date: ________________