



**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**

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

**Part B – Enrollment Information**

<u>Select Coverage Type – Who Is Being Enrolled – Check One Box Only</u> <input type="checkbox"/> Retiree Only <input type="checkbox"/> Spouse Only <input type="checkbox"/> Dependent Child Only <input type="checkbox"/> Retiree + 1 <input type="checkbox"/> Family	
<u>Select a Plan Option – Standard Plan/High Plan – Check One Box Only</u> <input type="checkbox"/> Standard Plan <input type="checkbox"/> High Plan	<u>Effective Date (MM/DD/YYYY)</u>

**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: \_\_\_\_\_