DELTA DENTAL

INDIVIDUAL ENROLLMENT/CHANGE APPLICATION

This application form must be received by Delta Dental of Iowa 10 days prior to the effective date. The effective date is always 1st of the month.

Product Choice: ☐ **Preventive** ☐ **Preferred Choice**	**Social Security No.**	**Effective Date** _____/__01__/_____

☐ **New Applicant** ☐ **Change of Coverage** ☐ **Name/Address Change**

SECTION I	**Name (First, Middle Initial, Last)**	**Telephone** ( )	**Date of Birth** ____/____/___	☐ **Male** ☐ **Female**

Complete Address – Street City State Zip	**Status:** ☐ Single ☐ Married ☐ Other (specify)_____
E-mail address:	**Please check the coverage you are applying for:** ☐ Single ☐ Two-person ☐ Family

SECTION II ELIGIBLE DEPENDENTS

List eligible members of your family to be covered **First Name Middle Initial Last (if different)**	**Social Security Number**	**Birthdate**	**Sex**	**Full-Time College Student**	**Disabled Status**	**Other Dental Coverage**
Spouse		___/___/__	☐ M ☐ F		Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes

Other Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete: **Contract holder:**_____

_____ ____/____/___ ☐ **Single** ☐ **Family**

Name of other dental carrier **Policy Number** **Effective Date** **Contract type**

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Dependents** ☐ **Terminating Benefits**

☐ **Other (explain)** _____ **Name of Affected Party** _____ **Date of Event** _____

SECTION IV AGREEMENT and CERTIFICATION

I have read and understand the Agreement and Certification of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE

_____ ____/____/____

Applicant Signature Date

Rohan Phillips / Benefit Solutions 7913453

Agent Name / Agency * NPN Insurance License #

Internal Use Only
Agency ID# _____

***This is the agency authorized by Delta Dental of Iowa to sell individual dental products.**

AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for individual coverage offered by Delta Dental of Iowa. I understand that I am responsible to pay monthly premium charges to Delta Dental of Iowa for this coverage, and if payment is not made when due, my coverage is subject to termination. I further understand that should this coverage be terminated, either voluntarily or involuntarily, I will not be eligible to apply for individual coverage offered by Delta Dental of Iowa for a period of 24 months from the date of termination. I understand that coverage for the dental care policy applied for will not start until after this application and the required monies for premium are received and accepted by Delta Dental of Iowa and an effective date is established by Delta Dental of Iowa. I understand that written notice of rate changes will be furnished by Delta Dental of Iowa at least 60 days prior to the effective date of any such rate change.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental of Iowa will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental of Iowa will be entitled to declare the dental care policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental of Iowa when reasonably related to the dental care coverage for which I have applied. If any law or regulation requires additional authorization for release of dental records, I will give this authorization.

To cancel coverage, Delta Dental of Iowa requires at least a 20-day written notice prior to the requested termination date to insure the automatic payments can be discontinued.

DELTA DENTAL OF IOWA
ACCOUNT WITHDRAWAL AUTHORIZATION - REQUIRED

I (we) hereby authorize Delta Dental of Iowa to initiate debit entries to the account indicated below, and the financial institution named below, to debit the same to such account. Personal checks cannot be accepted as payment for this product.

This authorization is for the purpose of paying monthly premiums for Delta Dental benefits, and I understand that the amounts are subject to change upon prior written notification to me at least 60 days in advance of any rate adjustment.

Monthly Withdrawal Date: ❒ 1st of month ❒ 5th of month

Bank Information:

_____ _____
Name of Financial Institution Branch (if applicable)

_____
Address of Financial Institution City State Zip Code

Account Type:

❒ Checking – please attach a **voided check** (deposit slips are NOT acceptable for checking account information)
❒ Savings – please attach a pre-printed deposit slip and indicate:
Bank Routing Number _____ Account Number _____

This authority is to remain in full force and effect until Delta Dental of Iowa has received written notification from me (us) of its termination. **Delta Dental requires a minimum of 20 days advance notice for termination of coverage in order to afford Delta Dental and the above named financial institution sufficient opportunity to process.**

_____ _____
Please Print Name of Insured Social Security Number of Insured

_____ _____
Signature of Payor Date Signed

Have you attached a voided personal check or a pre-printed personal savings account deposit slip from your financial institution?