Individual Enrollment/Change Application

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

Delta Dental of Iowa
PO Box 9010
Johnston, IA 50131 – 9010

Email: individualproduct@deltadentalia.com
Fax: 1-888-264-1433
Customer Service: 1-877-423-3582 x3

Section I Policyholder Information

Name (First, Middle Initial, Last)	Telephone No: ( )	Status: ☐Single ☐Married ☐ Other (Specify)_____________
Mailing Address – Street	**City**	**State** **Zip**
E-mail address		**Requested Effective Date:** ___ /01/____

Product Choice:
☐ Preventive ☐ Preferred ☐ Platinum

Do You Want Pediatric Dental Essential Health Benefits (EHB) that Meet the ACA Requirements:
☐ Yes ☐ No

Section II Persons to be Covered (include Yourself if applying for coverage)

First Name Middle Initial Last (if different)	Social Security Number	Birthdate	Sex	Other Dental Coverage
Self		___/___/___	☐ M ☐ F	☐No ☐Yes
Spouse		___/___/___	☐ M ☐ F	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐No ☐Yes
Eligible Child		___/___/___	☐ M ☐ F	☐No ☐Yes

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

____ ____/____/___ ☐ Single ☐ Family

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

Prior Dental Coverage - Has any person(s) on this application had prior dental coverage within the past 60 days? ☐ Yes ☐ No

Note: Your previous coverage will be verified. Credit towards waiting periods may be given for those individuals that were covered under a qualifying plan within the past 60 days. You will need to provide the following: verification of coverage on previous carrier's letterhead, coverage effective date and termination date, who was covered and a summary of benefits covered under your policy.

Section III Change of Coverage

Please check events requiring Contract changes:
☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **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

Agreement and Certification

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I am a resident of the state of Iowa. I understand I am applying for an application for individual dental coverage offered by Delta Dental of Iowa. I understand 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 I am not eligible to apply for individual dental coverage offered by Delta Dental of Iowa for a period of 24 months from the date of termination of a prior individual policy, either voluntarily or involuntarily, unless I had other continuous coverage with similar qualifying benefits. I understand if coverage under this application is terminated in the future, either voluntarily or involuntarily, I will not be eligible to apply for Delta Dental of Iowa individual coverage for a period of 24 months from the date of termination of my current Delta Dental of Iowa individual coverage, unless I have other continuous coverage with similar qualifying benefits. I understand that coverage for the dental policy applied for will not start until after this application and the required monies for the first month's premium are received and accepted by Delta Dental of Iowa and an effective date is established by Delta Dental of Iowa. Applications must be received by the 20th of the month to be effective the first of the following month. Applications received after the 20th will be effective the first of the next month.

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 policy applied for void and refuse allowance of benefits to any person hereunder.

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

DELTA DENTAL OF IOWA
ACCOUNT WITHDRAWAL AUTHORIZATION – REQUIRED

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

____

Name of Financial Institution

____

Address of Financial Institution City State Zip Code

Account Type: ☐ Checking (Please attach a voided check) ☐ Savings (Please attach pre-printed deposit slip)

Bank Routing Number ______________________Account Number ____________________________

I certify to the best of my knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).

I hereby authorize Delta Dental of Iowa and the financial institution named to withdraw monthly premium payments from my checking or savings account that I selected. I further authorize Delta Dental of Iowa to initiate adjustment entries to this account when necessary.

I understand my first month's premium will be withdrawn from my account starting on the 1st or 5th calendar day of the month of the policy effective date, and thereafter will be deducted on the 1st or 5th calendar day of each month. This authorization is for the purpose of paying monthly premiums for Delta Dental of Iowa Individual and Family Dental Insurance. I also understand the amounts are subject to change at least annually and Delta Dental will send me written notification of such changes at least 60 days before the rate change takes effect.

This authority for payments is to remain in full force and effect until Delta Dental of Iowa has received written notification from me of its withdrawal.

I understand in order to revoke my authorization provided, terminate coverage, or make changes to my payment information, I must contact Delta Dental of Iowa at TeamService@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010. **Please keep in mind that you must provide Delta Dental 20 days notice prior to the requested termination date. Termination dates are always the last day of the month**.

Delta Dental of Iowa SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, ANY DELAY IN THE ACTUAL DATE ON WHICH YOUR ACCOUNT IS DEBITED, OR YOUR FAILURE TO PROVIDE ACCURATE AND/OR VALID PAYMENT INFORMATION.

______________________ ______________________ ______________

Printed Name of Policyholder Name & Signature of Accountholder Date Signed

______________________ ______________________ ______________ ______________

Agent Name **Agency *** **NPN License #** **Broker #**

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