DELTA DENTAL®

Individual Enrollment/Change Application

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

Please complete application and send to:
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	**Product Choice:** ☐ Preventive ☐ Preferred Choice	**Requested Effective Date: ___ /01/____**

Application must be received by Delta Dental of Iowa 20 days prior to the requested effective date. Effective date is always 1st of the month.

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

First Name Middle Initial Last(if different)	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
Self		___/___/__	☐ M ☐ F		Disabled? ☐Yes	☐No ☐Yes
Spouse		___/___/__	☐ M ☐ F		Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Eligible Child		___/___/__	☐ 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 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 listing of benefits.

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 that I am an Iowa resident and that I am legally authorized to apply for coverage for myself and/or 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, unless I have had continuous coverage with similar benefits. 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 written notice to be received at least 20-days prior to the requested termination date to ensure the automatic payments can be discontinued in a timely manner..

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.

This authorization is for the purpose of paying monthly premiums for Delta Dental coverage. 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** (deposits slips are NOT acceptable for checking account information)

❒ Savings – please attach a pre-printed deposit slip and indicate for savings account only:
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 written notice to be received at least 20 days prior to the requested termination date in order to afford Delta Dental and the above named financial institution sufficient opportunity to process.**

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

_____ _____
Please Print Name of Insured Delta Dental ID Number

_____ _____
Signature of Insured Date Signed

*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions.

Please sign & return both pages of the application with a voided check or pre-printed savings account deposit slip

_____ _____ _____
Agent Name **Agency *** **NPN Insurance License #**

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