DELTA DENTAL®

DeltaVision®

Individual Enrollment/Change Application

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

1 POLICYHOLDER INFORMATION

Name _____ Telephone (_____) _____
First Middle Initial Last

Status: ☐ Single ☐ Married ☐ Other (Specify) _____

Mailing Address _____
Street City State Zip

Email Address _____ Requested Effective Date: _____/ 01 /_____

2 COVERAGE OPTIONS (please choose one option)

☐ **Dental Coverage Only**

Dental Plan Choice: ☐ Preventive ☐ Preferred ☐ Platinum

Do you want Pediatric Dental Essential Health Benefits (EHB) to meet the ACA requirements? ☐ Yes ☐ No

OR

☐ **Dental and Vision Coverage** with Hearing Discount

Dental Plan Choice: ☐ Preventive ☐ Preferred ☐ Platinum

Do you want Pediatric Dental Essential Health Benefits (EHB) to meet the ACA requirements? ☐ Yes ☐ No

3 PERSONS TO BE COVERED (include yourself if applying for coverage)

Complete the information below for each person to be covered under policies (or plans) selected above. All members enrolling who are from the same household should be included on the same enrollment form.

First Name, Middle Initial, Last Name	Social Security Number	Birthdate	Sex	Does the applicant have 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: _____

Name of other dental carrier | **Policy Number** | **Effective Date** | **Contract Type**

_____ | _____ | ___/___/___ | ☐ Single ☐ Family

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 who 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.

4 CHANGE OF COVERAGE (for existing members only)

Please check the event that caused the change:

☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Drop Covered Person ☐ Terminating Benefits

☐ Other (explain) _____

Name of affected party _____ Date of event _____

5 ACCEPTANCE OF COVERAGE

I have read and understand the Terms & Conditions (Section 6) and Customer Payment Verification and Authorization (Section 7) on the back of this application and acknowledge receipt of a fully completed copy of this application.

Applicant Signature X_____ **Date X**_____

(Over, please)

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

Email: individualproduct@deltadentalia.com • **Fax:** 1-888-264-1433 • **Customer Service:** 1-888-264-1432

6 TERMS & CONDITIONS

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 Individual and Family dental or Individual and Family dental and vision coverage offered by Delta Dental of Iowa ("Delta Dental") and Veratrus Benefit Solutions, Inc. ("VBS"). I understand I am responsible to pay monthly premium charges to Delta Dental (dental) and VBS (vision) for this coverage, and if payment is not made when due, my coverage is subject to termination. All persons applying for coverage (section 3) must be covered under the product(s) chosen. Additional persons within a family will be allowed to enroll with a qualifying event. I understand if I terminate my dental coverage, my vision coverage will terminate, if applicable. I further understand I am not eligible to apply for Individual and Family dental coverage offered by Delta Dental and/or Individual and Family vision coverage offered by VBS for a period of 24 months from the date of termination of a prior Individual and Family policy, whether the termination was voluntary or involuntary, 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 and/or VBS Individual and Family coverage for a period of 24 months from the date of termination of my current Individual and Family coverage, unless I have other continuous coverage with similar qualifying benefits.

I understand that coverage for the dental or dental/vision 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 and VBS (if applicable) and an effective date is established by Delta Dental. 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 and VBS 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 and VBS will be entitled to declare the dental and vision policy applied for void and refuse allowance of benefits to any person hereunder.

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

To update any information on my application, I will contact Delta Dental at 877-423-3582. If after examining the policy I am not satisfied with the terms for any reason, I may return the policy within 10 days of delivery and upon receipt, Delta Dental will refund any premiums paid.

7 PAYMENT INFORMATION (choose a payment method)

☐ **Pay by credit card**

Name as it appears on the card _____

Card type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

OR

Card number _____ Expiration date (MM/YYYY) _____

CVV code (3 or 4 digit code on the front or back of your card) _____

☐ **Pay by EFT** (checking/savings account)

Name of Financial Institution _____

Address of Financial Institution _____

Street City State Zip

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

Bank Routing Number _____ Account Number _____

X _____ X _____ X _____

Printed Name of Policyholder | Name & Signature of Accountholder | Date Signed

Delta Dental Customer Payment Verification and Authorization

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 grant Delta Dental authority to automatically charge my credit card or withdraw from my checking or savings account that was selected to pay my monthly premium payments. I further authorize Delta Dental to initiate adjustment entries to this account when necessary.

I understand, if I choose this method of payment, my first month's premium will be withdrawn from my checking or savings account immediately, and thereafter will be deducted on the 5th calendar day of each month. If I choose credit card payment, I understand my first month's premium will be charged to my credit card immediately. After that, I understand my premium will be charged to my credit card on the first business day of each month beginning after the policy effective date.

This authorization is for the purpose of paying monthly premiums for dental and vision policies. I also understand the amounts are subject to change at least annually and Delta Dental will send 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 and VBS have 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/VBS at IndividualProduct@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010. I understand I can also change payment information by going to www.deltadentalia.com and logging into the Member Connection portal. I understand that I must provide Delta Dental a 20 day notice prior to the requested termination date. I also understand, termination dates are always effective the last day of the month.

I UNDERSTAND, DELTA DENTAL AND/OR VBS SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT I MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, ANY DELAY IN THE ACTUAL DATE ON WHICH MY ACCOUNT IS DEBITED, OR MY FAILURE TO PROVIDE ACCURATE AND/OR VALID PAYMENT INFORMATION.

Agent Name _____ Agency* _____

NPN License # _____ Broker # _____

*This is an agency authorized by Delta Dental of Iowa to sell Individual and Family dental and vision products.

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentialia.com/nondiscrimination.

DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa.