DELTA DENTAL

DENTAL ENROLLMENT / CHANGE APPLICATION

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Social Security Number	Group Number	Effective Date ____/_____/_____
☐ New Applicant ☐ Change of Coverage ☐ Late Enrollee ☐ Name/Address Change	☐ Part-time to Full-time	Dept/EE Number

SECTION I	Name (First, Middle Initial, Last)	Telephone ( )	Date of Birth ____/____/___	☐ Male ☐ Female
Complete Address – Street City State Zip		Status ☐ Single ☐Married ☐ Other (specify)_____	Hire Date ___/___/___	
Employer Name & Location	Please check the coverage you are applying for: ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)			

SECTION II ADDITIONAL ELIGIBLE MEMBERS ELECTING COVERAGE

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
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
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 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 Spouse/Child(ren)** ☐ **COBRA** ☐ **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 and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE

_____ ____/____/____
Employee Signature Date

WAIVER OF COVERAGE

☐ I waive dental coverage for my dependents and myself.
(Please indicate reason)
☐ I (We) have coverage under another dental plan.
☐ I (We) do not wish to enroll

_____ ____/____/____
Employee Signature Date

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 the coverage sponsored by my employer or group sponsor offered by Delta Dental of Iowa. I authorize my employer, as my agent to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental of Iowa on my behalf. This authorization is to remain in effect until Delta Dental of Iowa is notified by me or my employer or group sponsor to the contrary. I understand that coverage for the dental care policy applied for will not start until after this application and the monies deducted from my pay for payment of the premium or paid to my employer for such 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 my employer or group sponsor as my agent.

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.

WAIVER OF COVERAGE

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Iowa, reserves the right to reject such an application.