



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.

marketing@deltadentalia.com
www.deltadentalia.com
Fax: 888-264-1433
Phone: 1-877-423-3582 x3

Product Choice: <input type="checkbox"/> Preventive <input type="checkbox"/> Preferred Choice	Social Security No.	Effective Date ____/____/01____
<input type="checkbox"/> New Applicant	<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Name/Address Change

SECTION I	Name (First, Middle Initial, Last)	Telephone ()	Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Complete Address – Street	City	State	Zip
			Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Other (specify) _____
E-mail address:		Please check the coverage you are applying for: <input type="checkbox"/> Single <input type="checkbox"/> Two-person <input type="checkbox"/> Family		
Please let us know how you heard about Delta Dental of Iowa's Individual Dental Product. <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Dentist Office <input type="checkbox"/> Internet <input type="checkbox"/> Other Media Ad <input type="checkbox"/> Friend / Relative <input type="checkbox"/> Other				

SECTION II ELIGIBLE DEPENDENTS

List eligible members of your family to be covered			Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
First Name	Middle Initial	Last (if different)						
Spouse				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dependent				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dependent				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dependent				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dependent				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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

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.

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 30 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 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.**

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 (Social Security Number)

Signature of Insured/Payor Date Signed

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

Please return this completed form along with your application for coverage.

Please return the completed form to: Delta Dental of Iowa PO Box 9010 Johnston, Iowa 50131-9010	or Fax to: 888-264-1433
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Have you attached a voided personal check or a pre-printed personal savings account deposit slip from your financial institution?