



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.

Delta Dental of Iowa
PO Box 788
Ankeny, Iowa 50021-0788
www.deltadentalia.com
1-877-983-3582
Fax: 515-261-5573

Product Choice: Preventive, Catastrophic, Comprehensive
Social Security No.
Effective Date
New Applicant, Change of Coverage, Name/Address Change

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

SECTION II ELIGIBLE DEPENDENTS

Table with 7 columns: List eligible members of your family to be covered, Social Security Number, Birthdate, Sex, Full-Time College Student, Disabled Status, Other Dental Coverage. Rows include Spouse and multiple Dependents.

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: _____

Name of other dental carrier, Policy Number, Effective Date, Contract type (Single/Family)

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes: Marriage, Death, Divorce, Birth/Adoption, Drop Dependents, Terminating Benefits, Other (explain)

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

