DELTA DENTAL®

Individual Enrollment/Change Application

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

DeltaVision®

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.

First Name, Middle Initial, Last (if different)	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 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 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 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 medical 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, starting on the 5th calendar day of the month of the policy effective date and thereafter will be deducted on the 5th calendar day of each month. If I chose 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.

2436-A10011 4/19 Promo Code: 100010

Required Federal Notice-Nondiscrimination and Accessibility

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 nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

Delta Dental of Iowa provides free language services to people whose primary language is not English. In addition, Delta Dental provides free services for people with disabilities such as auxiliary aids, written communication in other formats such as large print, audio or other formats. If you need these services, call 1-877-423-3582 x3, hearing impaired (TYY) call 1-888-287-7312.

Language Access Service

This Notice has Important Information. This notice has important information about your application or coverage through Delta Dental of Iowa. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-877-423-3582 x3.

Arabic –

يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Delta Dental of Iowa. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 1-877-423-3582 x3.

Chinese – 本通知有重要的訊息。本通知有關於您透過 Delta Dental of Iowa 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 字 1-877-423-3582 x3。

French – Cet avis contient des informations importantes. Cet avis contient des informations importantes concernant votre demande ou la couverture offerte par Delta Dental of Iowa. Prenez note des dates butoirs indiquées dans le présent avis. Vous devrez peut-être effectuer certaines démarches dans les délais prévus pour conserver votre couverture santé ou l'aide financière à laquelle vous pouvez prétendre. Vous avez le droit d'obtenir ces informations et de recevoir de l'aide dans votre langue gratuitement. Appelez le 1-877-423-3582 x3.

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Delta Dental of Iowa. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-877-423-3582 x3.

Hindi – इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या Delta Dental of Iowa के माध्यम से बीमे के बारे में महत्वपूर्ण जानकारी शामिल है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या लागतों में मदद के लिए आपको कुछ निश्चित समय-सीमाओं तक कार्रवाई करने की ज़रूरत हो सकती है। आपको कोई कीमत दिए बिना यह जानकारी और सहायता अपनी भाषा में प्राप्त करने का अधिकार है। 1-877-423-3582 x3 पर कॉल करें।

Karen – တၢ်ကွဲးနိၣ်အဝဲဆံးနၣ်အိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢအရူဒိၣ် တဖၣ်နၣ်လိၤ. တၢ်ကွဲးနိၣ်အဝဲဆံးအိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ အရူဒိၣ်ဘၣ်ယးဒီးနလံာ်ပတံထိၣ် မ့တမ့ၢ် တၢ်ကျၢ်ဘၢခီဖျိ Delta Dental of Iowa နၣ်လိၤ. ယုကွၢ်မ့ၢ်နံးမ့ၢ်သိအခိၣ်သ့ၣ်လၢတၢ်ကွဲးနိၣ်ဆံးတကၢ်. ဘၣ်သ့ၣ်သ့ၣ် နကဘၣ်ဟံးန့ၢ်မူဒါလၢမ့ၢ်နံးမ့ၢ်သိလၢတၢ်ဆၢတဲာ်ယာ်လၢနကဟ်ယာ်နတၢ်အိၣ် ဆူၣ်အိၣ်ချူတၢ်ကျၢ်ဘၢ မ့တမ့ၢ် တၢ်မၤစၢၤလၢနကဘၣ်ဟ့ၣ်အပူးနၣ်လိၤ. နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒီးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိၣ်ဒၣ် နဲလၢတလိၣ်ဟ့ၣ်အပူးဘၣ်နၣ်လိၤ. ကိး 1-877-423-3582 x3 တကၢ်.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Delta Dental of Iowa을 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 1-877-423-3582 x3로 전화하십시오.

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງ ງທ່ານໂດຍຜ່ານ Delta Dental of Iowa. ເບິ່ງກຳນົດການໃນແຈ້ງການສະບັບນີ້. ເບິ່ງກຳນົດການໃນແຈ້ງການສະບັບນີ້ ອກຳນົດວັນເວລາທີ່ແນ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼື ອໃນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-877-423-3582 x3.

Pennsylvania Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Delta Dental of Iowa. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Ruf yuscht selli Nummer uff: 1-877-423-3582 x3.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Delta Dental of Iowa. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры до определенного срока для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-877-423-3582 x3.

Bosnian/Croatian – U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko Delta Dental of Iowa. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-877-423-3582 x3.

Spanish – Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Delta Dental of Iowa. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-877-423-3582 x3.

Tagalog – Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Delta Dental of Iowa. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-877-423-3582 x3.

Thai – ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Delta Dental of Iowa ดูกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-877-423-3582 x3.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Delta Dental of Iowa. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-877-423-3582 x3.