DELTA DENTAL

Association Enrollment/Change Form

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

DeltaVision®

(Completed by the Association)

Group Number ________ **Effective Date** ___/___/___ **Department/EE Number** ________

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) ________ **Social Security Number** ________

Mailing Address **City** **State** **Zip** ________ **Status** ☐ Single ☐ Married ☐ Other (specify) ________ **Hire Date** ___/___/___

Telephone (______)________ ☐ Home ☐ Cell Phone **Email Address** ________

Employer Name ________ **Employer Location** ________

2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered First Name MI Last (if different)	Social Security Number	Birthdate	Sex	Coverage Selected	Full-Time College Student	Disabled Status	Other Dental Coverage
Self		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision		☐ Yes ☐ No	☐ No ☐ Yes
Spouse		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision		☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes

Dental Plan Choice* ☐ High Plan ☐ Low Plan
*Subscriber must be enrolled in dental and all members must be enrolled in the same plan.

Other Dental Coverage – if any person(s) on this application has other dental insurance please complete.

Policyholder ________

Name of Other Carrier(s) ________ Policy Number ________ Effective Date ___/___/___ Contract Type ☐ **Single** ☐ **Family**

3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

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

☐ **Other** (explain) ________ Name of Affected Party ________ Date of Event ___/___/___

4 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/WAIVER OF COVERAGE

☐ I accept the dental and/or vision coverage selected above.

☐ I waive dental coverage for my family members and/or myself. (Please indicate reason) ________

☐ I waive vision coverage for my family members and/or myself. (Please indicate reason) ________

X ________ ___/___/___

Signature Date

4 AGREEMENT AND CERTIFICATION (continued)

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental") and/or Veratrus Benefit Solutions, Inc. ("VBS"). I understand coverage for the dental and/or vision policy applied for will not start until after this application and the monies for the first month's premium are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

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 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 will be entitled to declare the dental and/or vision 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 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.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental and/or vision benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

5 PAYMENT INFORMATION (choose a payment method)

☐ **Pay by credit card**

Name as it appears on the card ____________________

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

Card number ____________________ Expiration date (MM/YYYY) ____________

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

OR

☐ **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 2nd calendar day 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. 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 the association for which I am enrolled as a subscriber. 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.

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.deltadentalia.com/nondiscrimination.

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

DELTA DENTAL®

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 1-877-983-3582, hearing impaired (TYY) call 1-888-287-7312.

Language Access Service

If you, or someone you're helping, has questions about Delta Dental of Iowa, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-983-3582.

Arabic –

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Delta Dental of Iowa، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-983-3582.

Chinese – 如果您，或是您正在協助的對象，有關於 Delta Dental of Iowa 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請致電 1-877-983-3582

French – Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Delta Dental of Iowa, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-983-3582.

German – Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Iowa haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-983-3582 an.

Hindi – यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Delta Dental of Iowa के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए 1-877-983-3582 पर कॉल करें।

Karen – နၤ, မ့တမ့ၢ် ပှၤတဂၤဂၤလၢနမၤစၢၤအီၤ, မ့ၢ်အိၣ်ဒီး တၢ်သံကွၢ်တဖၣ်ဘၣ်ဃးဒီးDelta Dental of Iowa န့ၣ်,နအိၣ်ဒီး တၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီး တၢ်ဂ့ၢ်တၢ်ကျိၤလၢ နကျိာ်ဒၣ် နဲလၢ တလိၣ်ဟ့ၣ်အပှ့ၤဘၣ်န့ၣ်လီၤ. လၢနက ကတိၤတၢ်ဒီး ပှၤကတိၤကျိာ်ထံတၢ်အဂီၢ်, ကိး1-877-983-3582တက့ၢ်.

Korean – 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Iowa에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-983-3582로 전화하십시오.

Laotian – ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Delta Dental of Iowa, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-983-3582.

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Delta Dental of Iowa, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-983-3582 uffrufe.

Russian – Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Iowa, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-983-3582.

Serbo-Croatian – Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Delta Dental of Iowa, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-983-3582.

Spanish – Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Iowa, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-983-3582.

Tagalog – Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Delta Dental of Iowa, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-983-3582.

Thai – หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Delta Dental of Iowa คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-877-983-3582

Vietnamese – Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Iowa, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-983-3582.