

## LARGE GROUP DENTAL ENROLLMENT / CHANGE APPLICATION

|   |                                    |   |                        |   |  |   |  |   |
|---|------------------------------------|---|------------------------|---|--|---|--|---|
| TeamService@deltadentalia.com<br>Fax: 1-888-558-9212<br>Phone: 1-877-983-3582<br><a href="http://www.deltadentalia.com">www.deltadentalia.com</a>   |                                    | Social Security No.   |                        | Group Number  |  | Effective Date<br>____/____/____  |  |   |
|   |                                    | <input type="checkbox"/> New Applicant <input type="checkbox"/> Change of Coverage<br><input type="checkbox"/> Late Enrollee <input type="checkbox"/> Name/Address Change |                        | <input type="checkbox"/> Part-time to Full-time   |  | Dept/EE Number  |  |   |
| <b>SECTION I</b>  | Name (First, Middle Initial, Last) |   |                        | Telephone<br>(    )   |  | Date of Birth<br>____/____/____   | <input type="checkbox"/> Male<br><br><input type="checkbox"/> Female |   |
|   | Complete Address – Street          |   | City                   | State   | Zip  | Status <input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Other (specify) _____ |  | Hire Date<br>____/____/____                                     |
| Employer Name & Location  |                                    |   |                        | Please check the coverage you are applying for:<br><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse<br><input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)          |  |   |  |   |
| I authorize Delta Dental of Iowa to notify me via e-mail to retrieve my Explanation of Benefits (EOB's) from the Delta Dental of Iowa's subscriber connection website @ <a href="http://www.deltadentalia.com">www.deltadentalia.com</a> . E-Mail: _____<br>Signature: _____  |                                    |   |                        |   |  |   |  |   |
| <b>SECTION II ELIGIBLE DEPENDENTS</b>   |                                    |   |                        |   |  |   |  |   |
| 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)   |                                    |   |                        | ____/____/____  | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>School Name:  | Disabled?<br><input type="checkbox"/> Yes                            | <input type="checkbox"/> No<br><input type="checkbox"/> Yes     |
| Spouse  |                                    |   |                        | ____/____/____  | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>School Name:  | Disabled?<br><input type="checkbox"/> Yes                            | <input type="checkbox"/> No<br><input type="checkbox"/> Yes     |
| Eligible Child  |                                    |   |                        | ____/____/____  | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>School Name:  | Disabled?<br><input type="checkbox"/> Yes                            | <input type="checkbox"/> No<br><input type="checkbox"/> Yes     |
| Eligible Child  |                                    |   |                        | ____/____/____  | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>School Name:  | Disabled?<br><input type="checkbox"/> Yes                            | <input type="checkbox"/> No<br><input type="checkbox"/> Yes     |
| Eligible Child  |                                    |   |                        | ____/____/____  | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>School Name:  | Disabled?<br><input type="checkbox"/> Yes                            | <input type="checkbox"/> No<br><input type="checkbox"/> Yes     |
| Eligible Child  |                                    |   |                        | ____/____/____  | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>School Name:  | Disabled?<br><input type="checkbox"/> Yes                            | <input type="checkbox"/> No<br><input type="checkbox"/> Yes     |
| Eligible Child  |                                    |   |                        | ____/____/____  | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>School Name:  | Disabled?<br><input type="checkbox"/> Yes                            | <input type="checkbox"/> No<br><input type="checkbox"/> Yes     |
| <b>Other Dental Coverage</b> - 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: <b>Contract holder:</b> _____<br>_____/____/____ <input type="checkbox"/> <b>Single</b> <input type="checkbox"/> <b>Family</b>   |                                    |   |                        |   |  |   |  |   |
| Name of other dental carrier  |                                    | Policy Number   |                        | Effective Date  |  | Contract type   |  |   |
| <b>SECTION III CHANGE OF COVERAGE</b>   |                                    |   |                        |   |  |   |  |   |
| <b>Please check events requiring Contract changes:</b><br><input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Drop Spouse/Child(ren) <input type="checkbox"/> COBRA <input type="checkbox"/> Terminating Benefits<br><input type="checkbox"/> Other (explain) _____ Name of Affected Party _____ Date of Event _____ |                                    |   |                        |   |  |   |  |   |
| <b>SECTION IV AGREEMENT and CERTIFICATION</b>   |                                    |   |                        |   |  |   |  |   |
| 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.  |                                    |   |                        |   |  |   |  |   |
| <b>ACCEPTANCE OF COVERAGE</b>   |                                    |   |                        | <b>WAIVER OF COVERAGE</b>   |  |   |  |   |
| _____<br>Employee Signature                      Date   |                                    |   |                        | <input type="checkbox"/> I waive dental coverage for my dependents and myself.<br>(Please indicate reason)<br><input type="checkbox"/> I (We) have coverage under another dental plan.<br><input type="checkbox"/> I (We) do not wish to enroll |  |   |  |   |
|   |                                    |   |                        |   |  |   |  | _____/____/____<br>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.

# 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](http://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 (TY) 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 1-877-983-3582.

### Arabic –

يحيوي هذا الإشعار معلومات هامة. يحوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Delta Dental of Iowa. ابحث عن التواريخ الهامة في هذا الإشعار. 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 1-877-983-3582.

**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 1-877-983-3582。

**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 1-877-983-3582.

**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 1-877-983-3582.

**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 कार्यवाई करने की ज़रूरत हो सकती है। आपको कोई कीमत दिए बिना यह जानकारी और सहायता अपनी भाषा में प्राप्त करने का अधिकार है। 1-877-983-3582 पर कॉल करें।

**Karen – တာ်ကွဲးနိဉ်အဝဲအံးနိဉ်အိဉ်ဒီးတာ်ဂု်တာ်ကျိလောအရူဒိဉ်**  
တဖဉ်နိဉ်လိာ်. တာ်ကွဲးနိဉ်အဝဲအံးအိဉ်ဒီးတာ်ဂု်တာ်ကျိလော  
အရူဒိဉ်ဘဉ်ယးဒီးနလံာ်ဝတံထိဉ် မ့တမ့ာ် တာ်ကျာ်ဘာဝါစိဉ် Delta Dental of Iowa နနိဉ်လိာ်. ယုကွာ်မုာ်နံးမုာ်သိအိဉ်သ့ဉ်လောတာ်ကွဲးနိဉ်အံးတက့ာ်. ဘဉ်သ့ဉ်သ့ဉ်နကဘဉ်ဟံးနုာ်မုာ်လောမုာ်နံးမုာ်သိလောတာ်ဆာတ်ဝါယာ်လောနကဟံာ်ယာ်နတံာ်အိဉ်အုဉ်အိဉ်ဂ့တုာ်ကျာ်ဘာ မ့တမ့ာ် တာ်မၤစၢလောနကဘဉ်ဟ့ဉ်အပူၤနနိဉ်လိာ်. နအိဉ်ဒီးတာ်ခွဲးတာ်ယာ်လောနကဒီးနုာ်ဘဉ်တာ်မၤစၢဒီးတာ်ဂု်တာ်ကျိလောနကျိဉ်ဒဉ်နဲလောတလိဉ်ဟ့ဉ်အပူၤဘဉ်နနိဉ်လိာ်. ကိး 1-877-983-3582 တက့ာ်.

**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. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움을 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 1-877-983-3582로 전화하십시오.

**Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນສໍາຄັນ.** ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັກ ຫຼື ການຄຸ້ມຄອງ ໆທ່ານໂດຍຜ່ານ Delta Dental of Iowa. ເບິ່ງກຳນົດການໃນແຈ້ງການສະບັບນີ້, ເບິ່ງກຳນົດການໃນແຈ້ງການສະບັບນີ້ ຍກຳນົດເວລາທີ່ແນ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງສະເພາະຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແຈ້ງການຊ່ວຍເຫຼືອ ອິນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-877-983-3582.

**Pennsylvania Dutch – Die Bekanntmachung gebt wichdichi Auskunft.** Die Bekanntmachung 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 beschtimme 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 koschet nix. Ruf yuscht selli Nummer uff: 1-877-983-3582.

**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 1-877-983-3582.

**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 određene 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 1-877-983-3582.

**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 1-877-983-3582.

**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 habkbang 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 1-877-983-3582.

**Thai – ประกาศนี้มีข้อมูลสำคัญ** ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอขอบเขตประกันสุขภาพของคุณผ่าน Delta Dental of Iowa. ดูกำหนดการในประเทศไทย คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-877-983-3582.

**Vietnamese – Thông báo này cung cấp thông tin quan trọng.** Thông báo này có thông tin quan trọng bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Delta Dental of Iowa. Xin xem ngay 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 giúp 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 1-877-983-3582.