



Individual Dental Exchange Enrollment Application

Please complete both sides of this form and sign on the back.
Please type or print legibly in dark blue or black ink. Thank you!

Type of Application:

New Enrollment

This application for dental insurance coverage is for:

Insured Only

Insured + Spouse

Family

Insured + Child(ren)

Applicant Name First	M.I.	Last	Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Applicant Social Security Number
Applicant Mailing Address			City	State	Zip
					Home Phone Number

Are you a resident of Alaska? Yes (In order to be eligible to enroll in this plan, you must be an Alaska resident)
 No

When did your employer-sponsored Delta Dental plan terminate? _____

Please write your employer name. _____

Dependent information

Name First	M.I.	Last	Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Spouse Name				<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent Name				<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent Name				<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent Name				<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent Name				<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent Name				<input type="checkbox"/> M <input type="checkbox"/> F	

Individual Dental Eligibility Requirements

You are eligible for individual dental coverage under this agreement if you meet the following requirements:

- You had 12 months of continuous coverage on a Delta Dental group employer-sponsored dental plan.
- You are applying within 90 days from the date your employer-sponsored plan terminated; or within 60 days from when we sent this offer.
- You are an Alaska resident.



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Enrollment Application

It is VERY important that you sign and date below. Thank you!

Billing Information: Choose One Option

Option 1: **Auto Pay Plan (Checking Account Deduction)**

BANK NAME: _____ BRANCH: _____

BANK ADDRESS: _____

BANK ACCOUNT NO: _____

This authority is to remain in full force and effect until Delta Dental Insurance Company and my bank have received written notifications from me of its termination in such time and in such manner as to afford Delta Dental Insurance Company and my bank a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such an error to the bank within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

- ATTACH A CHECK FOR ONE MONTH'S PREMIUM MADE PAYABLE TO DELTA DENTAL INSURANCE COMPANY
- ATTACH A "VOIDED" CHECK FROM WHICH YOU WANT THE PAYMENT WITHDRAWN
- FUNDS WILL TRANSFER ON OR AROUND THE FIFTH CALENDAR DAY OF EACH MONTH

X Signature _____ Date _____

Option 2: **Monthly Billing Statement**

- A \$2.00 MONTHLY ADMINISTRATION FEE IS REQUIRED WITH THIS PAYMENT METHOD
 - ATTACH A CHECK OR MONEY ORDER FOR ONE MONTH'S PREMIUM MADE PAYABLE TO DELTA DENTAL INSURANCE COMPANY. A BILL WILL BE SENT IN THE MAIL EVERY MONTH
- I understand that there is an administration fee for the monthly billing statement. I consent to pay the administration fee in addition to the monthly premium.

X Signature _____ Date _____

Option 3: **Quarterly Billing Statement (Self Pay)**

- ATTACH A CHECK OR MONEY ORDER FOR THREE MONTHS' PREMIUM MADE PAYABLE TO DELTA DENTAL INSURANCE COMPANY

X Signature _____ Date _____

FOR AGENT USE ONLY

I, (the Agent) certify I have explained the eligibility provisions to the Applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Delta Dental Insurance Company.

I CERTIFY THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent Name (Please print or type)

Agent Tax ID No.

Agency Name

Phone Number

Street Address

City

State

Zip

Agent Signature (Required)

Date

AGENT: COLLECT PREMIUM WITH APPLICATION

I understand mailing a check to Delta Dental Insurance Company does not guarantee coverage. My premium payment will not be credited to my account unless my application for the ODS Individual Dental Exchange Plan has been received by Delta Dental Insurance Company within the 90-day period following my loss of an employer-sponsored dental plan or the 90-day period following the beginning of my employer-sponsored medical plan. If Delta Dental Insurance Company receives my application within this 90-day period, the effective date of coverage will be the 1st of the month following the receipt of my application. If my application is not received within the 90-day period following the loss of the employer-sponsored dental plan or the 90-day period following the beginning of my employer-sponsored medical plan, Delta Dental Insurance Company will notify me in writing and my payment will be returned.

X Signature _____ Date _____

