DELTA DENTAL

Large Group Voluntary Enrollment/Change Application

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

TeamService@DeltaDentalia.com
www.deltadentalia.com

Fax: 1-888-558-9212
Phone: 1-877-983-3582

Group Number (Completed by Employer)	**Effective Date (Completed by Employer)** ____/_____/_____

SECTION I	**Name (First, Middle Initial, Last)**	**Social Security Number**	**Telephone** ( )

Mailing Address – Street City State Zip	**Status** ☐ Single ☐Married ☐ Other (specify)_____	**Hire Date** / /

Employer Name	**Employer Location**

Product Choice ☐ Catastrophic ☐Comprehensive ☐ Preventive	Please check the coverage you are applying for: ☐ **Employee Only** ☐ **Employee/Spouse** ☐ **EE/Child(ren)** ☐ **EE/Spouse/Child(ren)**

SECTION II ELIGIBLE MEMBERS ELECTING COVERAGE

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

Other Dental Coverage - If any person(s) on this application has other dental insurance please complete.
Contract holder:_____

_____ _____ ____/____/___ ☐ **Single** ☐ **Family**
Name of Other Dental Carrier **Policy Number** **Effective Date** **Contract type**

SECTION III 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** _____

SECTION IV 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 OF COVERAGE

_____ ____/____/____
Employee Signature Date

AGREEMENT AND CERTIFICATION

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 making application for the coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa. I authorize my employer, 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 I or my employer or Plan Sponsor notifies Delta Dental of Iowa to the contrary. I understand coverage for the dental policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental of Iowa. I further understand that Delta Dental of Iowa 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 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 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 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 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 benefits, which may require additional limitations and waiting periods. I also understand Delta Dental of Iowa, reserves the right to reject such an application.