DELTA DENTAL

Individual Enrollment/Change Application

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

Please complete application and send to:
Delta Dental of Iowa
PO Box 9010
Johnston, IA 50131 – 9010

Email: individualproduct@deltadentalia.com
Fax: 1-888-264-1433
Customer Service: 1-877-423-3582 x3

Section I Policyholder Information

Name (First, Middle Initial, Last)	**Telephone No:** ( )	**Status:** ☐Single ☐Married ☐ Other (Specify)_____
Mailing Address – Street	**City**	**State** **Zip**
E-mail address		**Requested Effective Date:** ___ /01/____
Product Choice: ☐ Preventive ☐ Preferred ☐ Platinum		**Do You Want Pediatric Dental Essential Health Benefits (EHB) that Meet the ACA Requirements:** ☐ Yes ☐ No

Section II Persons to be Covered (include Yourself if applying for coverage)

First Name Middle Initial Last (if different)	**Social Security Number**	**Birthdate**	**Sex**	**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: **Policyholde**r:_____

_____ ____/____/___ ☐ Single ☐ Family
Name of other dental carrier **Policy Number** **Effective Date** **Contract type**

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.

Section III Change of Coverage

Please check events requiring Contract changes:
☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **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 of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE

_____ ____/____/____
Applicant 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 am a resident of the state of Iowa. I understand I am applying for an application for individual dental coverage offered by Delta Dental of Iowa. I understand I am responsible to pay monthly premium charges to Delta Dental of Iowa for this coverage, and if payment is not made when due, my coverage is subject to termination. I further understand I am not eligible to apply for individual dental coverage offered by Delta Dental of Iowa for a period of 24 months from the date of termination of a prior individual policy, either voluntarily or involuntarily, 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 of Iowa individual coverage for a period of 24 months from the date of termination of my current Delta Dental of Iowa individual coverage, unless I have other continuous coverage with similar qualifying benefits. I understand that coverage for the dental 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 of Iowa and an effective date is established by Delta Dental of Iowa. 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 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 hereunder.

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.

DELTA DENTAL OF IOWA
ACCOUNT WITHDRAWAL AUTHORIZATION – REQUIRED

_____

Name of Financial Institution

_____

Address of Financial Institution City State Zip Code

Account Type: ☐ Checking (Please attach a voided check) ☐ Savings (Please attach pre-printed deposit slip)

Bank Routing Number _____Account Number _____

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 hereby authorize Delta Dental of Iowa and the financial institution named to withdraw monthly premium payments from my checking or savings account that I selected. I further authorize Delta Dental of Iowa to initiate adjustment entries to this account when necessary.

I understand my first month's premium will be withdrawn from my 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. This authorization is for the purpose of paying monthly premiums for Delta Dental of Iowa Individual and Family Dental Insurance. I also understand the amounts are subject to change at least annually and Delta Dental will send me 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 of Iowa has 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 of Iowa at IndividualProduct@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010. **Please keep in mind that you must provide Delta Dental 20 days notice prior to the requested termination date. Termination dates are always the last day of the month**.

Delta Dental of Iowa SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, ANY DELAY IN THE ACTUAL DATE ON WHICH YOUR ACCOUNT IS DEBITED, OR YOUR FAILURE TO PROVIDE ACCURATE AND/OR VALID PAYMENT INFORMATION.

_____ _____ _____

Printed Name of Policyholder Name & Signature of Accountholder Date Signed

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.