

## LARGE GROUP DENTAL ENROLLMENT / CHANGE APPLICATION

TeamService@deltadentalia.com Fax: 1-888-558-9212 Phone: 1-877-983-3582 <a href="http://www.deltadentalia.com">www.deltadentalia.com</a>	Group Number (Completed by Employer) _____	Effective Date (Completed by Employer) ____/____/____						
	<input type="checkbox"/> New Applicant <input type="checkbox"/> Change of Coverage <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) _____	Social Security Number _____	Telephone ( ) _____					
Complete Address – Street _____	City _____	State _____	Zip _____					
		Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other (specify) _____	Hire Date ____/____/____					
Employer Name & Location _____		Please check the coverage you are applying for: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <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: _____ Signature: _____								
<b>SECTION II ELIGIBLE MEMBERS ELECTING COVERAGE</b>								
List eligible members of your family 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				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes
Spouse				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Other Dental Coverage</b> - If any person(s) on this application has other dental insurance please complete: Contract holder: _____ _____/____/____ <input type="checkbox"/> Single <input type="checkbox"/> Family								
Name of other dental carrier		Policy Number		Effective Date		Contract type		
<b>SECTION III CHANGE OF COVERAGE</b>								
Please check events requiring Contract changes:								
<input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Drop Covered Person(s) <input type="checkbox"/> COBRA <input type="checkbox"/> Terminating Benefits <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>			
					<input type="checkbox"/> I waive dental coverage for my dependents and myself. (Please indicate reason) <input type="checkbox"/> I (We) have coverage under another dental plan. <input type="checkbox"/> I (We) do not wish to enroll			
_____/____/____			_____/____/____		_____/____/____		_____/____/____	
Employee Signature			Date		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.