DELTA DENTAL

LARGE GROUP DENTAL
ENROLLMENT / CHANGE APPLICATION

TeamService@deltadentalia.com
Fax: 1-888-558-9212
Phone: 1-877-983-3582
www.deltadentalia.com

Group Number- 35001

Effective Date (Completed by Employer) / /

☐ **New Applicant** ☐ **Change of Coverage**
☐ **Late Enrollee** ☐ **Name/Address Change**

☐**Part-time to Full-time** ☐**Part-time**
☐**Full time to Part-time** ☐**Full-time**

Dept/EE Number

SECTION I

Name (First, Middle Initial, Last)

Social Security Number

Telephone ( )

Complete Address – Street:
City:
State: Zip:

Status ☐ Single
☐Married
☐Other (specify)

Hire Date / /

Employer Name & Location
State of Iowa

Please check the coverage you are applying for:
☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ 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 @ www.deltadentalia.com. E-Mail: Signature:

SECTION II ELIGIBLE MEMBERS ELECTING COVERAGE

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

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 / /

WAIVER OF COVERAGE

☐ I waive dental coverage for my dependents and myself.
(Please indicate reason)
☐ I (We) have coverage under another dental plan.
☐ I (We) do not wish to enroll

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.