 **LARGE GROUP DENTAL**

**ENROLLMENT / CHANGE APPLICATION**

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| **TeamService@deltadentalia.com** Fax: 1-888-558-9212Phone: 1-877-983-3582[www.deltadentalia.com](http://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-timeFull 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](http://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.