

Dental plan coverage for Aware Care members

Enrollment application

Brought to you by Delta Dental of Minnesota

PART A – SUBSCRIBER INFORMATION

Subscriber's Name:	Last	First	Middle Initial	Social Security Number / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Day Phone Number ()	Evening Phone Number ()	Email Address	Date of Birth / /
Subscriber's Address:	Address		City	State Zip Code
Aware Care Member's XZ Number: Refer to your Medical ID Card to obtain number.				
Aware Care Agent Information:	Agent Name		Agent Phone Number	Agency Code/Number

PART B – ENROLLMENT OPTIONS – Select one plan option and one orthodontic option.

Aware Care Dental: <input type="checkbox"/> Plan A (\$50 Deductible/\$1250 Plan Maximum) <input type="checkbox"/> Plan B (\$100 Deductible/\$1000 Plan Maximum) <input type="checkbox"/> Yes, I Elect Orthodontic Coverage <input type="checkbox"/> No, I Do Not Elect Orthodontic Coverage				
Select Who Is To Be Enrolled: <input type="checkbox"/> Subscriber Only <input type="checkbox"/> Subscriber + One Dependent <input type="checkbox"/> Family (Three or More)				
Complete this section if you have selected the enrollment option of Subscriber + One Dependent or Family. If more than four family members are being enrolled, attach a list of additional dependent information in the below format. Dependent children age 19-25 must be full-time students to be eligible.				
Relationship to Subscriber	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Subscriber's)	Gender	Date of Birth Month/Day/Year	If Age 19-25, Full-Time Student?
Spouse/Domestic Partner		M F	/ /	
Dependent Child		M F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART C – PAYMENT OPTION INFORMATION – Select one payment option and billing frequency.

<input type="checkbox"/> A. Direct Withdrawal from Checking Account: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual Name on Checking Account: _____ Bank Name: _____ Routing Number: _____ Checking Account Number: _____ The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.	
<input type="checkbox"/> B. Credit Card: <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> American Express <input type="checkbox"/> Discover (include CVC2 code from back of card) <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa Credit Card Number _____ Exp. Date ____/____/____ Discover CVC2 Code _____ Name As It Appears On Credit Card _____ The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.	
<input type="checkbox"/> C. Check: <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual Send a check with this form payable to Delta Dental of Minnesota. Future premiums will be billed prior to the start of each coverage period. When paying by check, there is <u>no</u> monthly payment option. If you wish to pay monthly, select the Direct Withdrawal option.	

PART D – AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I have read the information contained in the application and choose to enroll. I understand the benefits and restrictions of this plan as stated in the material provided with the application. I certify the information contained in this application is true and complete. I understand my enrollment is subject to receipt of payment and verification of funds. If I have selected Payment Option A or B, I authorize Delta Dental to withdraw funds from my checking account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made timely I will no longer be eligible for coverage. The start and cancellation dates of my insurance coverage will be determined by Delta Dental of Minnesota. The start date is generally the first day of the month following receipt of the enrollment application. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand that I must enroll for one full year and if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of two years.

Subscriber Signature: _____ **Date:** _____

Send Completed Application To: Individual Dental
Delta Dental of Minnesota Attn: Enrollment Department
P.O. Box 330 Minneapolis MN 55440-0330