

Delta Dental plan coverage for Aware Care and Personal Blue members

Enrollment application

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 ()	e-mail Address	Date of Birth / /
Subscriber's Address:	Address		City	State ZIP Code
Aware Care or Personal Blue Member's XZ Number: Refer to your Medical ID Card to obtain number.				
Aware Care or Personal Blue Agent Information:	Agent Name		Agent Phone Number	Agency Code/Number

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

Dental: **Plan A** (\$50 Deductible/\$1250 Plan Maximum) **Plan B** (\$100 Deductible/\$1000 Plan Maximum)
 Yes, I Elect Orthodontic Coverage **No, I Do Not Elect Orthodontic Coverage**

Select Who Is To Be Enrolled: Subscriber Only Subscriber + One Dependent 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 unmarried children through age 24 are eligible to enroll.

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	Dependent Unmarried?
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.

A. Direct Withdrawal from Checking Account: **Monthly** **Quarterly** **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.

B. Credit Card: **Quarterly** **Annual**
 American Express Discover MasterCard Visa
 Credit Card Number _____ Exp. Date ____/____
 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.

C. Check: **Quarterly** **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.

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