



Enrollment or Update Form for: Individual and Family Dental Plans

Enroll online now at www.DeltaDentalNE.org/shop/ or complete this application and mail (along with a check) if applicable, to:

Delta Dental of Nebraska
Individual and Family Plans
PO Box 74008401
Chicago, IL 60674-8401

If you have any questions about filling out this form, please contact our Individual Customer Service at (866) 764-5350.

New Enrollment—Check for first-time enrollment

Change/Correction to Information—Check if any changes are being submitted on this form

Termination of Benefits—Check only if you are terminating coverage for you and/or your dependents

This section must be completed for us to process your enrollment or update your records. **Please print clearly.**

Subscriber Name (First)		(M.I.)	(Last)	Example	A B C D E F 1 2 3 4 5 6
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Birth Date	Sex	Subscriber Social Security Number - Requested but not required			
<input type="text"/> <input type="text"/> <input type="text"/>	Male Female	<input type="text"/> - <input type="text"/> - <input type="text"/>			
Street Address					Check here if this is a new address
<input type="text"/>					
City			State	ZIP Code	
<input type="text"/>			<input type="text"/>	<input type="text"/> - <input type="text"/>	
Email Address (Optional)				Telephone Number	
<input type="text"/>				<input type="text"/> - <input type="text"/> - <input type="text"/>	
New Coverage / Change / Termination Effective Date *			*New enrollments must start on the first of a future month		
<input type="text"/> - <input type="text"/> - <input type="text"/>			*Requested termination date must be the last day of the current or a future month (except in the case of death)		
(Requested date of new coverage, change in coverage or termination)			*If change, reason for change _____		

Spouse Information (Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)

Spouse Name (First)		(M.I.)	(Last)
<input type="text"/>		<input type="text"/>	<input type="text"/>
Birth Date	Sex		
<input type="text"/> <input type="text"/> <input type="text"/>	Male Female		

Dependent Child Information #1

Dependent Child Name (First)		(M.I.)	(Last)
<input type="text"/>		<input type="text"/>	<input type="text"/>
Birth Date	Sex		
<input type="text"/> <input type="text"/> <input type="text"/>	Male Female		

Dependent Child Information Continued: #2

Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

#3 - Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

#4 - Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

#5 - Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

For additional dependents, please provide complete information on a separate piece of paper and include with this form.

Plan and Payment Information - The amount payable for coverage varies based on the coverage option selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling.

Plan Options (select only one):

- Delta Dental Individual and FamilySM - Plan A (\$50 Deductible/\$1,200 Annual Plan Maximum)
- Delta Dental Individual and FamilySM - Plan B (\$100 Deductible/\$1,000 Annual Plan Maximum)
- Delta Dental Individual and FamilySM - Plan C (\$100 Deductible/\$500 Annual Plan Maximum)

Payment Frequency:

- Annual (If you are paying by check, you must choose this option and pay the amount due in full)
- Monthly (If you are paying by credit card or automatic withdrawal, please choose this option)

Choose the payment method:

- Check payable to Delta Dental (you may pay by check only if you choose an annual payment)
- MasterCard VISA Discover American Express

Card Number

Exp. Date

 -

Cardholder Name (as it appears on card)



___ - ___ - ___ CVV Code (last three digits on the back of your Credit Card)

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Nebraska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Nebraska does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Nebraska provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Nebraska provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you believe that Delta Dental of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Nebraska, Attn: Complaints, Appeals, and Grievances, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ForeignLanguageNotifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-643-3582 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-643-3582 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-643-3582 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-643-3582 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-643-3582 (TTY : 711)。 (Chinese) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-643-3582 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ ສຽງຄຳ, ຄຸ້ມຄອງ ພາສາໃຫ້ທ່ານ. ໂທ 1-855-643-3582 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አገልግሎቶች፣ በዚህ ሊያገለግሉት ተዘጋጅተዋል። 1-855-643-3582 (መስማት ለተሳናቸው: 711). (Amharic)

1-855-643-3582 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-643-3582 (TTY: 711). (German)

1- 855- 643- 3582 مقرب لصتا. ناچملااب كل رفلاوتت فيوغلا ددعاسملا تامدخ نإف، ةغللا ركذا نثحتت تنك اذا: ةظوحلم ه مصلا مكبلاو: (Arabic) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Appelez le 1-855-643-3582 (ATS : 711). (French)

주의: 한국어를 한국어 사용하시는 경우, 언어 지원 서비스를 무료로 무료로 이용하실 수 있습니다. 1-855-643-3582 (TTY: 711)번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-643-3582 (TTY: 711). (Tagalog)

هتسه در هب. (Kurdish) پراداگای: رهگهی هب ینامز یدروک هسهق تیهکده، یناکهیراز وگتھمزخ یتھمراى نامز، بیارۆ خهب، ۆب ۆت هکب. (TTY: 711) 1-855-643-3582

هجوٓت: رگا هب نابز یسراف وگتفگ یم دینک، تالیهست ینابز تروصب ناگیار یارب امش. دیریگب اب. دشاب یم ف (TTY: 711) سامت (Persian / Farsi) 1-855-643-3582

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-643-3582 (TY:711) まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-643-3582 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-643-3582 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistenttjenester tilgjengelige for deg. Ring 1-855-643-3582 (TTY: 711). (Norwegian)

ស ម ្រ ង ប យ ក ៖ រ ូ ប ស ័ ប អ ្រ ក ័ យ [០០ ០៩១១], ០ស០៥ ៩ យ ០០ ០០យកកក កថ្ម, ០ដលអកក រ ្រ រ ប ០ស ០ស។ ស ម ្រ ង ៧ ០ 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

धयनकषण : यद तप [नप ल] ब लनहनछ भन, नःशलक पम तप लई भष सहयत सवह उपलबध छन 1-855-643-3582 (TTY: 711) (Nepali)