DELTA DENTAL®

Individual and Family Dental Plan Enrollment/Update

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

Delta Dental of Nebraska
Individual Product Unit
PO Box 74008401
Chicago, IL 60674-8401

If you have any questions about filling out this form, please contact our Individual Customer Service at (855) 663-5677.

- ❑ 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

If this a request for a new enrollment, have you had dental coverage in the past? If yes, please provide the **Carrier's name** and **start and end date of the policy**. ☐ Yes ☐ No

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

Subscriber Name Example ABCDEF123456

(First) *(M.I.)* *(Last)*

Birth Date Sex

Male ☐ Female ☐

Subscriber Social Security Number

– –

❑ Check here if this is a new address

Street Address

City State ZIP Code –

E-mail Address (Optional) Telephone Number – –

New Coverage / Change / Termination Effective Date *

– –

(Requested date of new coverage, change in coverage or termination)

*New enrollments must start on the **first** of a future month
*Requested termination date must be the **last day** of the current or a future month (except in the case of death)
*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)

Birth Date Sex

Male ☐ Female ☐

Dependent Child Information

#1 - Dependent Child Name (First) (M.I.) (Last)

Birth Date Sex

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(s) selected and the number of people enrolled.

Pediatric Plan Option - applies to all enrolled members under age 19 :

❑ Delta Dental Individual and Family℠ Kids Plan

Adult Plan Options (must select one if plan includes a member over age 18):

❑ Delta Dental Individual and Family℠ – Bronze
❑ Delta Dental Individual and Family℠ – Silver
❑ Delta Dental Individual and Family℠ – Gold
❑ Delta Dental Individual and Family℠ – Platinum

Payment Frequency:

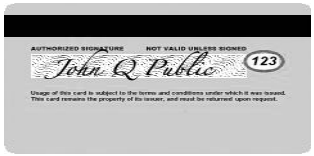
❑ Monthly

Choose the payment method:

❑ **Check** payable to Delta Dental
❑ **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)

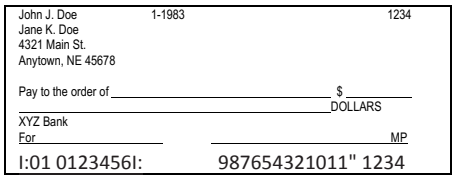
Credit Card Billing Address (if different from mailing address)

Street Address

City State ZIP Code –

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for premiums due. This authorization will remain in effect until Delta Dental has received written notice from me of its termination. If the billing amount changes, Delta Dental will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature _____ Date _____


John J. Doe 1-1983 1234
Jane K. Doe
4321 Main St.
Anytown, NE 45678

Pay to the order of _____ $ _____
_____ DOLLARS
XYZ Bank
For _____ _____ MP
I:01 0123456I: 987654321011" 1234

Routing number Account number

❑ **Automatic withdrawal from bank account**

Bank Name

Routing Number Account Number

❑ Checking Account

❑ Savings Account

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature _____ Date _____

Agent Information If an agent is assisting in the purchase of this policy, please enter the agent information below:

Agent Name _____ Agent NPN _____

Authorization and Verification

I have read the information contained in the application and choose to enroll or make the changes indicated. 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. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim against civil damages. I understand my enrollment is subject to receipt of payment and verification of funds. The start and end dates of coverage will be determined by Delta Dental of Nebraska. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting cancellation 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 at any time, for any reason re-enrollment restrictions will apply, according to the contract.

Subscriber's Signature_____ **Date** _____