DELTA DENTAL

Enrollment or Update Form for:
Individual and Family Dental Plans
Individual and Family Dental + Vision Plans

HVN Health Ventures Network

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

Delta Dental of Minnesota
Individual and Family Plans
PO Box 74008400
Chicago, IL 60674-8400

If you have any questions about filling out this form, please contact our Individual Customer Service at (855) 643-3582.

☐ 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.**

Example A B C D E F 1 2 3 4 5 6

Subscriber Name (First) (M.I.) (Last)

Birth Date

Sex ○ Male ○ Female

Subscriber Social Security Number - Requested but not required

☐ Check here if this is a new address

Street Address

City State ZIP Code

Email 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 selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling.

Dental Plan Options (select only one):

- ☐ Delta Dental Individual and Family℠ – Plan A ($50 Deductible/$1,200 Annual Plan Maximum)
- ☐ Delta Dental Individual and Family℠ – Plan B ($100 Deductible/$1,000 Annual Plan Maximum)
- ☐ Delta Dental Individual and Family℠ – Plan C ($100 Deductible/$500 Annual Plan Maximum)
- ☐ Delta Dental Individual and Family℠ – Plan D ($50 Deductible/$1,250 Annual Plan Maximum)

Dental + Vision Plan Options (select only one):

- ☐ Delta Dental Individual and Family℠ – Plan A with DeltaVision® administered by EyeMed Vision Care®
- ☐ Delta Dental Individual and Family℠ – Plan B with DeltaVision® administered by EyeMed Vision Care®
- ☐ Delta Dental Individual and Family℠ – Plan C with DeltaVision® administered by EyeMed Vision Care®
- ☐ Delta Dental Individual and Family℠ – Plan D with DeltaVision® administered by EyeMed Vision Care®

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)

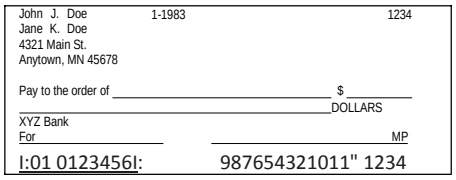
Credit Card Billing Address (if different from mailing address)

Street Address

City State ZIP Code –

I hereby authorize Delta Dental of Minnesota, its subsidiaries, and its affiliates to charge my credit card for premiums due. This authorization will remain in effect until Delta Dental of Minnesota has received written notice from me of its termination. If the billing amount changes, Delta Dental of Minnesota or Health Ventures Network, if applicable, 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, MN 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

☐ Checking Account
☐ Savings Account

Routing Number

Account Number

I hereby authorize Delta Dental of Minnesota, its subsidiaries, and its affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental of Minnesota 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 Minnesota and/or Health Ventures Network. 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** _____

Delta Dental of Minnesota is an authorized licensee of the Delta Dental Plans Association of Oak Brook, Illinois.
DeltaVision® is administered by EyeMed Vision Care® and underwritten by Health Ventures Network.

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota and its affiliate, Health Ventures Network, (collectively referred to herein as "Delta Dental of Minnesota") comply 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 Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card.

If you believe that Delta Dental of Minnesota 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 Minnesota, Attn: Compliance Officer, 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 dị ch 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: ຖາວາ ທານເ ວາພາສາ ລາວ, ກາ ນບ ລການ ຊ ວຍເ ຫອ ດານພາສາ, ໂ ດ ຍບເ ສຽ ຄາ, ແ ມ ນມ ພອມໃ ຫ ທານ. ໂ ທຣ 1-855-643-3582 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 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)

مقرب لصتا . ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ : ةظوحلم ه مصلا مكبلاو: 1- 855- 643- 3582 (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 한국어를 사용하시는 사용하시는 사용하시는 경우 , 언어 지원 서비스를 서비스를 무료로 무료로 이용하실 이용하실 수 있습니 있습니 다. 1-855-643-3582 (TTY: 711)번으로 전화해 주십시오 십시오 . (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)

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزارییەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. (Kurdish) پەیوەندی بە 1-855-643-3582 (TTY: 711) بکە.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-855-643-3582 تماس بگیرید. (Persian / Farsi)

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 språkassistansetjenester tilgjengelige for deg. Ring 1-855-643-3582 (TTY: 711). (Norwegian)

ស ម្ប □ រងបយ ត□: រ◌បស ន ប អ□កន □យ [□□ ◌ខ□រ], ◌ស□ជ ន យ□□ ◌□យឥតគ តថ□, ◌ដលអ□ក□ រច រ ប □ស □ន។ស ម□ទ រស ព□ 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

धय न कषण : **य□द तप □ [नप ल□] ब लनहनछ भन**, **□न:शलक पम तप □लई भ ष सह यत सव ह उपलबध छन** 1-855-643-3582 (TTY: 711) (Nepali)