



## When does coverage begin?

Your coverage begins on the first day of the month following the date we receive your application, enrollment fee and initial premium. The initial coverage period is for 12 months. We guarantee not to change your premiums during those 12 months, and you agree to pay premiums on time for those 12 months. Only dental treatments begun and completed while coverage is in force are eligible for benefits.

## Complete details in Dental Benefit Plan Summary

This coverage at a glance is intended to provide a convenient overview of coverage and is not intended to be a complete description. Only those services and supplies specifically listed in the Dental Benefit Plan Summary are covered under the plan, regardless of dental necessity. Please note that treatment for a missing tooth is not immediately covered under the plan.

The Dental Benefit Plan Summary is your source for complete information, including the specific dental treatments covered, the frequency with which those treatments are covered, benefit amounts, limitations, exclusions and conditions under which coverage may remain in force. Exclusions and limitations are also available on our Web site, [www.deltadentalmn.org](http://www.deltadentalmn.org).

You will receive the Dental Benefit Plan Summary with your SingularDental welcome package. If you decide this coverage is not for you, simply let us know in writing within 10 days of receiving the Summary. We will promptly refund your paid premium and enrollment fee, and any claims incurred will not be paid.

3560 Delta Dental Drive  
Eagan, MN 55122

Phone: 651.406.5959  
Toll-free: 1.800.704.6993

[www.deltadentalmn.org](http://www.deltadentalmn.org)

# Follow our lead when it comes to your oral health.



## SingularDental<sup>SM</sup>

Affordable dental coverage for individuals age 50+ and their eligible dependents

DELTA DENTAL OF MINNESOTA

## Benefits of SingularDental include:

### Freedom

- See any dentist you like, with the greatest savings at a network dentist.
- Enjoy access to the SingularDental network. Finding a network dentist is easy – visit [www.deltadentalmn.org](http://www.deltadentalmn.org) and click “Dentist Search” to locate one near you, or call us toll-free at 1-800-704-6993.

### Protection

- Coverage for a broad spectrum of care (see chart for details), including 100% coverage for your routine check-ups when you see a network dentist.
- No waiting periods.

### Savings

- Choose between two great plans – one for greater coverage and one for lower premiums.
- Peace of mind knowing you have coverage for expensive emergency care – especially important for anyone on a fixed budget.
- Coverage for emergency procedures whether you’re at home or traveling – a great feature if you spend your winters outside Minnesota.

### Get started today

Simply complete the enclosed enrollment form, along with your billing information or a check (including initial premium and enrollment fee). If you select the annual payment option, we’ll waive the one-time \$25 enrollment fee. We accept payment by check, credit card or monthly bank draft.

## A dental plan for Minnesotans age 50 and over

Delta Dental of Minnesota, your hometown dental partner for nearly four decades, knows how important oral health is for all of life’s stages. Seniors, in particular, face a range of special oral health concerns, which makes comprehensive dental care a top priority.

If you’re not already covered through a group dental plan because you’re self-employed, working part-time or retired, having an individual dental plan can make a lot of sense for your oral health – and save you some dollars and cents, too.

Follow our lead and get started on the right foot with **SingularDental** from Delta Dental of Minnesota. Affordable plans start at just **\$23.89** a month.

We offer these plans as a service to Minnesotans age 50+ along with their spouse (any age); unmarried dependent children through age 24; and other dependents eligible under Minnesota law.

**Call us at 651-406-5959,**  
**toll-free at**  
**1-800-704-6993**  
**or enroll online at**  
**[www.deltadentalmn.org](http://www.deltadentalmn.org)**

# SingularDental<sup>SM</sup> - Coverage at a Glance

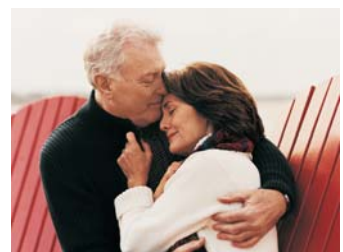
Coverage	PLAN 1		PLAN 2	
	In-network	Out-of-network	In-network	Out-of-network
<b>Diagnostic/Preventive</b> (Routine check-up)	<b>We pay 100%</b> You pay nothing	<b>We pay 100%</b> of Maximum Allowable Fee*	<b>We pay 100%</b> You pay nothing	<b>We pay 100%</b> of Maximum Allowable Fee*
<b>Basic Restorative</b> (Fillings, etc.)	<b>We pay 75%</b> You pay 25%	<b>We pay 50%</b> You pay 50%*	<b>We pay 75%</b> You pay 25%	<b>We pay 50%</b> You pay 50%*
<b>Major Restorative</b> (Crowns, bridges, oral surgery, etc.)	<b>We pay a set amount</b> (For example, \$250–\$300 for a typical crown). You pay the remainder*	<b>We pay 30%</b> You pay 70%*	<b>We pay a set amount</b> (For example, \$250–\$300 for a typical crown). You pay the remainder*	<b>We pay 30%</b> You pay 70%*
<b>Annual Deductible</b> Per Person	<b>\$50</b> <i>No deductible for diagnostic/preventive</i>	<b>\$50</b>	<b>\$25</b> <i>No deductible for diagnostic/preventive</i>	<b>\$25</b>
<b>Annual Plan Maximum</b> Per Person	<b>\$750</b>	<b>\$750</b>	<b>\$1,500</b>	<b>\$1,500</b>

\* You also pay any charges above the Maximum Allowable Fee. The Maximum Allowable Fee is the maximum amount we consider reasonable for a given dental procedure. **SingularDental network dentists will not charge more than the Maximum Allowable Fee for preventive, diagnostic and basic restorative services.** Non-network dentists are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-network dentist.

For example, when you receive a routine **check-up from a SingularDental network dentist**, you incur **no out-of-pocket cost**. When you receive a routine **check-up from a non-network dentist**, you are likely to incur **out-of-pocket costs**. The reason is that we will pay 100% of our Maximum Allowable Fee. If your non-network dentist charges more than that fee, you are responsible for paying your dentist the difference.

Premiums	PLAN 1			PLAN 2		
	Monthly	Quarterly	Annually	Monthly	Quarterly	Annually
<b>Subscriber</b>	<b>\$23.89</b>	\$71.67	\$286.68	<b>\$31.72</b>	\$95.16	\$380.64
<b>Subscriber + One</b>	<b>\$46.59</b>	\$139.77	\$559.08	<b>\$61.86</b>	\$185.58	\$742.32
<b>Family</b>	<b>\$69.29</b>	\$207.87	\$831.48	<b>\$92.00</b>	\$276.00	\$1,104.00

If you are enrolling for the first time and paying monthly or quarterly, there is also a one-time \$25 enrollment fee.



**PART A – APPLICANT INFORMATION** – Applicant must be at least age 50.

<b>Applicant's Name:</b>	Last	First	Middle Initial	<b>Social Security Number</b> / /
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	Day Phone Number	Evening Phone Number	Email Address	<b>Date of Birth</b> / /
<b>Applicant's Address:</b>	Address			
	City	State	Zip Code	

**PART B – ENROLLMENT OPTIONS**

**Select One Plan Option:**  **Plan 1** (\$50 Deductible/\$750 Plan Maximum)  **Plan 2** (\$25 Deductible/\$1500 Plan Maximum)

**Select Who Is To Be Enrolled:**  Applicant Only  Applicant + One Dependent  Family (Three or More)

Complete this section if you are enrolling one or more family members. If you are enrolling more than three family members, attach a list of additional dependent information in the below format. Dependent unmarried children through age 24 are eligible to enroll.

Relationship To Applicant	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Applicant's)	Gender	Date of Birth Month/Day/Year	Dependent Unmarried?
Spouse		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

**PART C – PAYMENT OPTION INFORMATION** – Select a payment option and a billing frequency. Note: A \$25 one-time enrollment fee applies unless you choose the annual payment option.

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

Name on Checking Account: \_\_\_\_\_ Bank Name: \_\_\_\_\_  
 Routing Number: \_\_\_\_\_ Checking Account Number: \_\_\_\_\_  
 If applicable, the enrollment fee will be charged with your first premium. 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 \_\_\_\_\_  
 If applicable, the enrollment fee will be charged with your first premium. 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. Please include the enrollment fee with quarterly premium. 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. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages. I understand my enrollment is subject to receipt of payment and verification of funds. 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 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. 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.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_