



**Individual Dental Plan for
Blue Cross and Blue Shield of Minnesota
Medicare Supplement/Medicare Select Members
Enrollment Application**

Delta Dental of Minnesota

When completing this enrollment application, use a pen and print clearly. If information is missing or illegible, this form may be returned and it can delay your enrollment. For information or assistance in completing this form, call Customer Service at 1-888-223-2954. **Send completed application to:**

Delta Dental of Minnesota ♦ Attn: Enrollment Department ♦ PO Box 330 ♦ Minneapolis MN 55440-0330.

PART A – ENROLLEE INFORMATION

Enrollee's Name:	Last	First	Middle Initial	Social Security Number / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Day Phone Number ()	Evening Phone Number ()	Email Address	Date of Birth / /
Enrollee's Address:	Address		City	State Zip Code
Blue Cross / Blue Plus Member ID Number:			Group Number	
Indicate the Blue Cross Medicare supplement plan you are enrolling in:				
<input type="checkbox"/> Senior Gold (SM) <input type="checkbox"/> Extended Basic Blue <input type="checkbox"/> Basic Blue <input type="checkbox"/> Enhanced Plan K <input type="checkbox"/> Enhanced Plan L				

PART B – PAYMENT OPTION INFORMATION – Select 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: _____
 Please send a voided check or copy of a voided check with this application. 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 C – 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 30 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.

Enrollee Signature: _____ **Date:** _____

FOR AGENT USE ONLY

Agent Name:	Agent Phone:
Agency Code:	Agent's Number: