

**Delta Dental of Minnesota Enrollment Application**

When completing this enrollment application, use an ink 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 – SUBSCRIBER INFORMATION**

<b>Subscriber'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>Subscriber's Address:</b>	Address				
	City	State	Zip Code		

**PART B – ENROLLMENT OPTIONS**

**Select One Plan Option:**  **Plan A** (\$50 Deductible/\$1200 Plan Maximum)  **Plan B** (\$100 Deductible/\$1000 Plan Maximum)

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

Complete this section if you have selected the enrollment option of Subscriber + One Dependent or Family. If more than three family members are being enrolled, attach a list of additional dependent information in the below format. Dependent unmarried children through age 24 are eligible to enroll.

Relationship to Subscriber	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Subscriber'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 payment option and billing frequency. Note: A \$25 one-time enrollment applies unless you choose the annual payment option.

**Select One 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: \_\_\_\_\_

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.

**Note:** When paying by check, there is no monthly payment option. If you wish to pay monthly, select the Direct Withdrawal.

**C. Check:**  Quarterly  Annual Send this form and a check payable to Delta Dental of Minnesota. Please include the enrollment fee with if selecting quarterly billing. Future premiums will be billed prior to the start of each coverage period.

**Note:** When paying by check, there is no monthly payment option. If you wish to pay monthly, select the Direct Withdrawal.

**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 for a period of two years.

**Subscriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_