



## Individual Dental for Simply Blue 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 – 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 ( )	e-mail Address	<b>Date of Birth</b> / /
<b>Subscriber's Address:</b>	Address		City	State ZIP Code
<b>Subscriber's XZ Number:</b> Refer to your Medical ID Card to obtain number.				
<b>Agent Information:</b>	Agent Name		Agent Phone Number ( )	Agency Code/Number

#### PART B – ENROLLMENT OPTIONS – Select the plan option in which you are enrolling.

<b>Dental Plan Options:</b>	<input type="checkbox"/> <b>Plan A</b> (\$250 Deductible/\$1250 Plan Maximum) <input type="checkbox"/> <b>Plan B</b> (\$100 Deductible/\$1250 Plan Maximum) <input type="checkbox"/> <b>Plan C</b> (\$100 Deductible/\$1250 Plan Maximum – includes Major Coverage)
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#### PART C – PAYMENT OPTION INFORMATION – Select payment option and billing frequency.

<input type="checkbox"/> <b>A. Direct Withdrawal from Checking Account:</b> <input type="checkbox"/> <b>Monthly</b> <input type="checkbox"/> <b>Quarterly</b> <input type="checkbox"/> <b>Annual</b> 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.	
<input type="checkbox"/> <b>B. Credit Card:</b> <input type="checkbox"/> <b>Quarterly</b> <input type="checkbox"/> <b>Annual</b> <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> 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.	
<input type="checkbox"/> <b>C. Check:</b> <input type="checkbox"/> <b>Quarterly</b> <input type="checkbox"/> <b>Annual</b> 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 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:** \_\_\_\_\_