DELTA DENTAL

Delta Dental Individual and Family - Singular for AAA Members
Enrollment Application

Delta Dental of Minnesota

When completing this enrollment application, use an ink pen and print clearly. If information is missing or illegible, this form will be returned and it will delay your enrollment. For information or assistance in completing this form, call Customer Service at 651-406-5959. Send completed application to: Delta Dental of Minnesota ♦ Attn: Enrollment Department ♦ PO Box 330 ♦ Minneapolis MN 55440-0330.

PART A – SUBSCRIBER INFORMATION – Subscriber must be a AAA Minneapolis (Mpls) member.

Subscriber's Name: **Primary AAA Mpls Member**	Last	First	Middle Initial	**Social Security Number** / /
Gender: ☐ Male ☐ Female	Day Phone Number	Evening Phone Number	Email Address	**Date of Birth** / /
Subscriber's Address:	Address			
	City	State	Zip Code	
Primary AAA Mpls Membership Number:				

PART B – ENROLLMENT OPTIONS

Select One Plan Option: ☐ **Plan 1** ($25 Deductible/$1000 Plan Maximum) ☐ **Plan 2** ($25 Deductible/$1500 Plan Maximum)

Select Who Is To Be Enrolled: Your AAA and Singular membership categories must match.
☐ Subscriber Only ☐ Subscriber + One Dependent ☐ Family (Three or more)

Complete this section if you selected the enrollment option of Subscriber+One or Family. If more than four family members are being enrolled, attach a list of additional dependent information in the below format. Dependent children can only be enrolled up to age 23.

Relationship to Primary AAA Mpls Member	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Subscriber's)	Gender		Date of Birth Month/Day/Year
Spouse/Domestic Partner		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

PART C – PAYMENT OPTION INFORMATION – Select a payment option and 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: _____
The first premium including the enrollment fee (if applicable) 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 ____/____ Security Code _____
Name As It Appears On Credit Card _____
The first premium including the enrollment fee (if applicable) 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 this form and your check payable to Delta Dental of Minnesota for the first quarter's premium plus the enrollment fee or the annual 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 that 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:**