DELTA DENTAL®

Delta Dental Individual and Family Enrollment Form

Delta Dental of Minnesota
Dental Enrollment Department
PO Box 330
Minneapolis MN 55440-0330

Please complete in blue or black ink only. For information or assistance in completing this form, call Customer Service at 1-888-223-2954.

Applicant Information – To be eligible to enroll, an applicant cannot currently be covered by another Delta Dental of Minnesota group or individual dental plan. Children under age 19 may apply for Pediatric Plan; however, a parent/guardian must sign the application and is responsible for payments.

Last Name	First Name	Middle Initial	Social Security Number

Gender ☐ M ☐ F	Day Phone Number	E-mail Address	Date of Birth

Address	City	State	ZIP Code

Have you had dental coverage in the past: ☐Yes ☐No If yes, when did coverage start _____ When did coverage end _____
Previous insurance carrier's name _____ What was your Policy Number _____

Agent Name	Agent Tax ID	Agent License	Agent Phone Number

Agent Email Address

Select Plan: Select one Adult Dental Plan for adult(s) and/or dependent child(ren) age 19+ being enrolled. Select a Pediatric Dental Plan for dependent child(ren) under age 19 being enrolled.

Adult Dental ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan G
Pediatric Dental ☐ Plan A ☐ Plan B

You can submit this application up to three months in advance of when you would like coverage to start. Coverage starts on the first day of the Requested Start Month. If you do not provide a start month, coverage will begin the first of the month after we receive your completed application.
Requested Start Month _____

Select Who Is To Be Enrolled: ☐ Applicant Only ☐ Applicant and Dependent (s)

Complete this section if anyone other than the applicant listed above is being enrolled. Dependent children under age 26 can be enrolled.

Relationship to Applicant	First Name, Middle Initial, Last Name	Gender		Date of Birth (mm/dd/yyyy)
☐Spouse ☐Domestic Partner		M	F	
Dependent Child		M	F	
Dependent Child		M	F	

Select One Payment Option and Billing Frequency The first premium is charged immediately. Future premiums are deducted/charged around the 6th business day of each payment period.

☐ **A. Direct Withdrawal from Checking/Savings Account:** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual**
Name on Checking Account _____
Bank Name _____
Routing Number _____ Checking Account Number _____

☐ **B. Credit Card or Debit Card**: ☐ **Monthly** ☐ **Quarterly** ☐ **Annual** ☐ MasterCard ® ☐ Visa ®
Credit/Debit Card Number _____ Exp. Date _____ Security Code _____
Name As It Appears On Credit/Debit Card _____

☐ **C. Check:** ☐ **Quarterly** ☐ **Annual** Send this form and a check payable to Delta Dental of Minnesota.

Authorization and Verification – Sign and date application as verification of your enrollment.

I have read, or have had read to me, the completed application and I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy. I authorize Delta Dental to withdraw funds from my bank account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made on time 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 if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of 12 months.

Applicant/Parent Signature: **Date:**