



# Individual and Family Dental Plan Enrollment/Update

Enroll online now at [www.DeltaDentalMN.org/shop](http://www.DeltaDentalMN.org/shop) or complete this form and mail, along with a check, if applicable, to:

Delta Dental of Minnesota  
Individual Product Unit  
PO Box 74008400  
Chicago, IL 60674-8400

If you have any questions about filling out this form, please contact our Individual Customer Service at (855) 643-3582.

- New Enrollment—Check for first-time enrollment
- Change/Correction to Information—Check if any changes are being submitted on this form
- Termination of Benefits—Check only if you are terminating coverage for you and/or your dependents

If this a request for a new enrollment, have you had dental coverage in the past? If yes, please provide the **Carrier's name** and **start and end date of the policy**.  Yes  No

This section must be completed for us to process your enrollment or update your records. **Please print clearly.**

Subscriber Name (First)  (M.I.)  (Last)  Example **ABCDEF123456**

Birth Date    Sex Male  Female  Subscriber Social Security Number - Requested but not required.  -  -

Street Address   Check here if this is a new address

City  State  ZIP Code  -

E-mail Address (Optional)  Telephone Number  -

New Coverage / Change / Termination Effective Date \*  -  -  \*New enrollments must start on the **first** of a future month  
 \*Requested termination date must be the **last day** of the current or a future month (except in the case of death)  
 (Requested date of new coverage, change in coverage or termination) \*If change, reason for change

**Spouse Information** (Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)

Spouse Name (First)  (M.I.)  (Last)

Birth Date    Sex Male  Female

**Dependent Child Information #1 -**

Dependent Child Name (First)  (M.I.)  (Last)

Birth Date    Sex Male  Female

**Dependent Child Information Continued:**

#2 - Dependent Child Name (First)

(M.I.) (Last)




Birth Date

Sex

Male

Female

#3 - Dependent Child Name (First)

(M.I.) (Last)




Birth Date

Sex

Male

Female

#4 - Dependent Child Name (First)

(M.I.) (Last)




Birth Date

Sex

Male

Female

#5 - Dependent Child Name (First)

(M.I.) (Last)




Birth Date

Sex

Male

Female

For additional dependents, please provide complete information on a separate piece of paper and include with this form.

**Plan and Payment Information** - The amount payable for coverage varies based on the coverage option selected and the number of people enrolled.

**Pediatric Plan - applies to all enrolled members under age 19**

Delta Dental Individual and Family<sup>SM</sup> Kids Plan

**Adult Plan Options (must select one if plan includes a member over age 18):**

- Delta Dental Individual and Family<sup>SM</sup> – Bronze
- Delta Dental Individual and Family<sup>SM</sup> – Silver
- Delta Dental Individual and Family<sup>SM</sup> – Gold
- Delta Dental Individual and Family<sup>SM</sup> – Platinum

Payment Frequency:

Monthly

Choose the payment method:

Check payable to Delta Dental

MasterCard

VISA

Discover

American Express

Card Number

Exp. Date

 - 

Cardholder Name (as it appears on card)



- - CVV Code (last three digits on the back of your Credit Card)

Credit Card Billing Address (if different from mailing address)

Street Address

[Grid for Street Address]

City

State

ZIP Code

[Grids for City, State, ZIP Code]

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for premiums due. This authorization will remain in effect until Delta Dental has received written notice from me of its termination. If the billing amount changes, Delta Dental will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature \_\_\_\_\_ Date \_\_\_\_\_

John J. Doe	1-1983	1234
Jane K. Doe		
4321 Main St.		
Anytown, MN 55678		
Pay to the order of _____ \$ _____		DOLLARS
XYZ Bank		
For _____		MP
!01 0123456!	987654321011"	1234

Automatic withdrawal from bank account

Routing number Account number

Bank Name

[Grid for Bank Name]

Routing Number

Account Number

Checking Account

[Grid for Routing Number]

[Grid for Account Number]

Savings Account

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Agent Information** If an agent is assisting in the purchase of this policy, please enter the agent information below:

Agent Name \_\_\_\_\_ Agent NPN \_\_\_\_\_

**NOTE:** This document is also available in alternative formats upon request and at no cost to persons with disabilities.

To receive this document in a language other than English, please contact the numbers below.

**Authorization and Verification**

I have read the information contained in the application and choose to enroll or make the changes indicated. I understand the benefits and restrictions of this plan as stated in the information 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 against civil damages. I understand my enrollment is subject to receipt of payment and verification of funds. The start and end dates of coverage will be determined by Delta Dental of Minnesota. If I decide I do not want the contract, I may return it within the 10-day grace period which allows a person the chance to cancel without obligation with a free look at the policy. 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 this contract continues until December 31<sup>st</sup> each year, as long as the premium is paid.

Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card.

If you believe that Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Minnesota, Attn: Stephanie Albert, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-460-3102, or email; [legal@deltadentalmn.org](mailto:legal@deltadentalmn.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-643-3582 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-643-3582 (TTY: 711). (Hmong)

XIYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-643-3582 (TTY: 711). (Cushite)

CHÚ Y: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-643-3582 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-643-3582 (TTY : 711)。 (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-643-3582 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າ ກົວ ກໍ ກຳ ນົວ ກຳ ນາ ສາ ລາວ, ອັດ າ ນາ ນາ ສາ, ໂດ ຍ ບ ຕ ສ ງ ອ າ, ແ ມ ນ ນ ິ ມ ພ ອ ມ ໃ ທ ື ທ າ ນ. ໂທ 1-855-643-3582 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን፣ በእነ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-855-643-3582 (መስማት ለተሳናቸው፡ 711). (Amharic)

ဟံသုန်ဟံသး- မုဟ်ကတိၤ ကညိၣ် ကျိၣ်ဆသိၣ်. မုဟ်မုဟ် ကျိၣ်ဆတၢ်မၤစၢၤလၢ တၢ်လၢဟ်ဘျုးလၢဟ်စ့ၤ နီတၢ်ဟ်ဘျုးသုန့ၣ်လိၤ. ကိၤ 1-855-643-3582 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-643-3582 (TTY: 711). (German)

1 برقم اتصلا. بالامجاز ل ك تتوافر اللغوية الامساعدة خدمات فإذ، للاغة اذكر تتحدث كنت إذا: ملحوظة -711-855-643-3582 (رقم). مكبلاو مصلا ه (Arabic)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-643-3582 (ATS : 711). (French)

주의: 한국어를 한국어를 사용하시는 사용하시는 사용하시는 경우, 언어 지원 서비스를 서비스를 무료로 무료로 이용하실 이용하실 수 있습니다. 1-855-643-3582 (TTY: 711)번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-643-3582 (TTY: 711). (Tagalog)

تۆ بۆ، بېھزورايي، زمانه یارمهتی خزمهتگوزاریهکانیه، دهکهیته قهسه کوردیه زمانیه به یهگهر: ئاگاداریه (Kurdish) بهردهسته بکهر. (TTY: 1-855-643- 711) پ به 3582

بگیرید. شما براین رایگان بصورت زبانی تسهیلات، کنید چه گفتگو فارسی زبان به اگر: توجه  
711 (Persian) / (Farsi) 1-855-643-3582 تماس: (TTY: ف چه باشد. با )

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-643-3582 (TY:711) まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-643-3582 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-643-3582 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistanstjenester tilgjengelige for deg. Ring 1-855-643-3582 (TTY: 711). (Norwegian)

សូមប្រាប់យើង: [សំណួរសំណួរសំណួរ], [សំណួរសំណួរសំណួរ], [សំណួរសំណួរសំណួរ], [សំណួរសំណួរសំណួរ], [សំណួរសំណួរសំណួរ], [សំណួរសំណួរសំណួរ] 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

ध्यानाकषणः यद् तपा [नेपाल] बेह ुन्छ भने, नःशक रूपमा तपालाई भाषा सहायता 1-855-  
सेवाहरू उपलब्ध छन्

643-3582 (TTY: 711) मा कल

गनहस। (Nepali)