



Individual and Family Dental Plan Enrollment/Update

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

Delta Dental of Minnesota - Serving North Dakota
Individual Product Unit
PO Box 74008405
Chicago, IL 60674-8405

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 No
yes, please provide the **Carrier's name** and **start and end date of the policy**.

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	A B C D E F 1 2 3 4 5 6
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Birth Date	Sex	Subscriber Social Security Number			
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>			
Street Address <input type="text"/>					
City <input type="text"/> State <input type="text"/> ZIP Code <input type="text"/> - <input type="text"/>					
E-mail Address (Optional) <input type="text"/>				Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>	
New Coverage / Change / Termination Effective Date *		*New enrollments must start on the first of a future month			
<input type="text"/> - <input type="text"/> - <input type="text"/>		*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 the change _____			

Check here if this is a new address

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)
<input type="text"/>		<input type="text"/>	<input type="text"/>
Birth Date	Sex		
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>		

Dependent Child Information #1 -

Dependent Child Name (First)		(M.I.)	(Last)
<input type="text"/>		<input type="text"/>	<input type="text"/>
Birth Date	Sex		
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>		

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 Option - applies to all enrolled members under 19

Delta Dental Individual and FamilySM Kids Plan

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

- Delta Dental Individual and FamilySM – Bronze
- Delta Dental Individual and FamilySM – Silver
- Delta Dental Individual and FamilySM – Gold
- Delta Dental Individual and FamilySM – Platinum

Payment Frequency:

Monthly

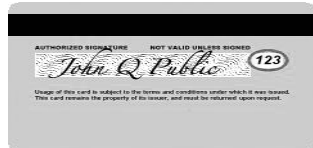
Choose the payment method:

- 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 fields

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 _____

Bank information box: John J. Doe, Jane K. Doe, 4321 Main St., Anytown, ND 45678. Pay to the order of _____ \$ _____ DOLLARS. XYZ Bank. For _____ MP. I:01 01234561: 987654321011" 1234. Routing number Account number

Automatic withdrawal from bank account

Bank Name

Grid for Bank Name

Account type and routing/account numbers: Checking Account, Savings Account, Routing Number, Account Number

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 _____

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 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 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 10 days after receipt with a written statement requesting cancellation 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 at any time, for any reason re-enrollment restrictions will apply, according to the contract.

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, email: 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)

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

CHÚ Ý: 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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-643-3582 (TTY: 711). (Laotian)

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

ဟံသုဂ်ဟံသု:- နမုကတိကညီ ကျိန်ဆယ်, နမုနု ကျိန်ဆတ်မလစာလေ တလက်ဘျဉ်လက်စု နီတမံဘဉ်သုနုဉ်လီ. ကိ: 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)

711) رقم . رقم 1-855-643-3582 اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن ،اللغة اذكر تتحدث كنت إذا :ملحوظة (Arabic) (ه الصم والبكم):

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 사용하시는 경우, 언어 지원 서비스를 무료로 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)

بكه. بهردسته (Kurdish) تو بۆ بهخوڕایی، زمان یارمهتی خزمهتگوزاریهکانی، دهکهیت قهسه کوردی زمانی به نهگهر: ناگاداری پ به 1-855-643-3582 (TTY: 711)

بگیرید. شما برای رایگان بصورت زبانی تسهیلات، کنید می گفتگو فارسی زبان به اگر: توجه

ف می باشد. یا 1-855-643-3582 (TTY: 711) تماس (Persian / Farsi)

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)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षणः यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, निःशुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-855-643-3582 (TTY: 711) मा कल गर्नुहोस्। (Nepali)