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, 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.

<table>
<thead>
<tr>
<th>Subscriber Name</th>
<th>Example</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Subscriber Social Security Number</th>
<th>New Coverage / Change / Termination Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(First)</td>
<td>(M.I.)</td>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
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E-mail Address (Optional)

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<tr>
<th>Telephone Number</th>
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New Coverage / Change / Termination Effective Date *

(Requested date of new coverage, change in coverage or termination)

*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)
*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.)

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<th>Spouse Name</th>
<th>Sex</th>
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Dependent Child Information #1 -

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<tr>
<th>Dependent Child Name</th>
<th>Sex</th>
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Plan and Payment Information - The amount payable for coverage varies based on the coverage option selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling.

Plan Options (select only one):

- Delta Dental Individual and Family℠ – Plan A ($50 Deductible/$1,200 Annual Plan Maximum)
- Delta Dental Individual and Family℠ – Plan B ($100 Deductible/$1,000 Annual Plan Maximum)
- Delta Dental Individual and Family℠ – Plan C ($100 Deductible/$500 Annual Plan Maximum)

Payment Frequency:

- Annual (If you are paying by check, you must choose this option and pay the amount due in full)
- Monthly (If you are paying by credit card or automatic withdrawal, please choose this option)

Choose the payment method:

- Check payable to Delta Dental (you may pay by check only if you choose an annual payment)
- 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

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 ____________

☐ Automatic withdrawal from bank account

Bank Name

Routing Number

Account Number

☐ Checking Account

Routing Number

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 ________________

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: Complaints, Appeals, and Grievances, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. 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.


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)


XIYYEEFFANAA: Afaan dubbatu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-643-3582 (TTY: 711). (Cushtite)

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)

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

www.DeltaDentalMN.org
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)

Kurdish: Рэханэ: ھەکب ەبی نامە یەکەکە، ئەنەکەر ئازوگەپەوە پەنھەڕەیان یەکە لەو سەربەیەکە، ئەپەرەخەیە، ھەکب 1-855-643-3582 (TTY: 711)

(Persian / Farsi) 1-855-643-3582 (TTY: 711) (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（TTY: 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. Woterefon 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 språkassistansetjenester tilgjengelige for deg. Ring 1-855-643-3582 (TTY: 711). (Norwegian)

SAMET (Samt) 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

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