

New Applicant    
  Change of Coverage    
  Name/Address Change

## Employer Choice

(Completed by Employer)

Group Number     
 Effective Date  /  /     
 Department/EE Number

### 1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last)     
 Social Security Number

Mailing Address     
 City     
 State     
 Zip     
 Status  Single  Married  Other (specify)     
 Hire Date  /  /

Telephone (  )     
 Home  Cell Phone    
 Email Address

Employer Name     
 Employer Location

### 2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered			Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
First Name	MI	Last (if different)						
Self				<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spouse				<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Other Dental Coverage** - if any person(s) on this application has other dental insurance please complete.

Policyholder

Name of Other Dental Carrier(s)     
 Policy Number     
 Effective Date  /  /     
 Contract Type  Single  Family

### 3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

Marriage   
 Death   
 Divorce   
 Birth/Adoption   
 Drop Covered Person   
 COBRA   
 Terminating Benefits   
 Part-Time to Full-Time

Other (explain)     
 Name of Affected Party     
 Date of Event  /  /

### 4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

#### ACCEPTANCE/WAIVER OF COVERAGE

I accept the dental coverage selected above.

I waive dental coverage for my family members and/or myself. (Please indicate reason)

**X**     
 /  /

Employee Signature    
 Date

## **AGREEMENT AND CERTIFICATION**

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental"). I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for the dental policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental will be entitled to declare the dental and/or vision policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental when reasonably related to the dental coverage for which I have applied for. If any law or regulation requires additional authorization for release of dental and/or vision records, I will give this authorization.

## **WAIVER OF COVERAGE**

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

## **NONDISCRIMINATION AND ACCESSIBILITY**

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to [www.deltadentalia.com/nondiscrimination](http://www.deltadentalia.com/nondiscrimination).