DELTA DENTAL®

Delta Dental Individual and Family™

ANNUAL RENEWAL CHANGE FORM

This Renewal Form should only be completed if you want to make changes or cancel Delta Dental Individual and Family Coverage. No action is necessary to continue existing coverage, unless the requested changes will alter your premium rate or annual payment is due.

DELTA DENTAL OF KANSAS MUST BE NOTIFIED OF REQUESTED CHANGES AT LEAST 5 BUSINESS DAYS BEFORE YOUR RENEWAL DATE.

SECTION 1 - ACCOUNT HOLDER'S CURRENT INFORMATION: **REQUIRED** (Please type or print legibly)

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ ,Kansas ZIP: _____

Social Security No.: _____ Date of Birth: _____

Email: _____ Phone: _____

SECTION 2 - CHANGES: (Please mark all appropriate boxes that apply to changes you wish to make)

☐ Name Change: **From:** _____ **To:** _____

For a Name Change Qualifying Event, documentation must accompany this form. Including, but not limited to, Court Order; Marriage License; or Divorce Decree.

☐ Address Change: **From: Address Listed Above** **To:** _____

☐ Add/Terminate Dependents: **Complete Section 3**

☐ Change Plan Type: **Complete Section 4**

☐ Change Payment Method: **Complete Section 5**

☐ Terminate Policy: **Complete Section 7**

SIGN SECTION 6 TO AUTHORIZE CHANGES

SECTION 3 - DEPENDENT INFORMATION: (List ONLY eligible family members to be enrolled or affected by change)

Action	Social Security Number	Spouse Name (First, MI and Last)	Birth Date
☐ Add ☐ Terminate			

Action	Social Security Number	Dependent Name (First, MI) (Last, If Different)	Birth Date
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			

SECTION 4 - PLAN INFORMATION: (If you wish to change plan types, please indicate below) NOTE: Only available at renewal.

Please check the plan you wish to enroll in: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze

Please check the type of coverage you are purchasing: ☐ Individual ☐ Individual + 1 ☐ Family

SECTION 5 - PAYMENT METHOD: (If you wish to change payment method, please indicate below) NOTE: Monthly payments only.

PLEASE NOTE: Credit card or checking/savings account payments can only be used for monthly payments. If you prefer to pay for a full year's coverage, checks are the only form of payment accepted. Return this completed form, with your check made out to Delta Dental of Kansas.

Pay by Credit Card:

Select Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number: _____ Expiration Date: _____ 3-Digit Security Code: _____

OR

Pay by Checking or Savings Account:

Account Type: ☐ Checking ☐ Savings Bank Name: _____

Name on Account: _____

Routing Number: _____ Account Number: _____

SECTION 6 - SIGNATURE/AUTHORIZATION

I hereby authorize Delta Dental of Kansas, Inc. to apply the changes indicated above to my individual dental policy.

Authorization/Signature for Change(s): _____ Date: _____

SECTION 7 - TERMINATION OF COVERAGE: (Complete ONLY if you or your family are cancelling coverage)

DELTA DENTAL OF KANSAS REQUIRES 30 DAYS NOTICE ON TERMINATIONS/QUALIFYING EVENTS PRIOR TO EFFECTIVE DATE

I understand that in the event I should decide to apply for coverage at a later date, I may be subject to waiting periods and/or limitations.

Authorization/Signature for Cancellation of Coverage: _____ Date: _____

Print Name: _____ Social Security Number: _____

Return to Delta Dental of Kansas
eligibility@deltadentalks.com | Fax 316.462.3394 | P.O. Box 789769 Wichita, KS 67278-9769

Questions? Contact us at 800.234.3375