DELTA DENTAL®

Delta Dental Individual and Family™

ENROLLMENT FORM

Thank you for enrolling in your Delta Dental Individual and Family plan. Please note that your enrollment form and payment must be received on or before the 25th of the month for coverage to start the first of the following month. If your form is received after the 25th of the month, your plan will be effective the first of the next month. Once we receive your enrollment, you will then receive your member ID cards by mail in 7-10 days.

CHOOSE YOUR PLAN:

Select Your Plan: ◉ Platinum Plan ○ Gold Plan ○ Silver Plan ○ Bronze Plan

How many people will be covered under your plan?: ○ Individual (1) ○ Individual +1 (2) ◉ Family (3+)

ACCOUNT HOLDER INFORMATION

The Account Holder is the individual who is authorized to renew, make changes to, and terminate the plan. *You must be at least 18 years of age and a Kansas resident. Your address entered below will be the address we will send plan communication to.*

Last Name: _____ First Name: _____

Address: _____

City: _____, Kansas ZIP: _____

Social Security No.: _____ Date of Birth: _____

Are you, the Account Holder, enrolling to be covered under the dental plan? ◉ Yes ○ No

Phone: _____ Email: _____

ADDITIONAL COVERED MEMBERS

List all additional covered members/dependents you are enrolling. ***Please note, the address you've entered above will be where member ID cards for all covered members are sent.*** *If additional space is required, attach a list to this form with the needed information. (Unmarried dependent children are covered through the end of the month in which they turn 26.)*

	Last Name	First Name	Social Security No.	Date of Birth (mm/dd/yyyy)
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

PRIOR DENTAL COVERAGE

☐ **Check here if you have been covered under a dental insurance plan within the last 60 days.**

Prior Carrier Name: _____ Prior Policy Number: _____ Termination Date: _____

PAYMENT METHOD

If you enroll using this paper application, you must submit a check or money order for one year of coverage. Please make your check payable to ***Delta Dental of Kansas***. If you prefer to pay automatically each month from a credit/debit card or checking account withdrawal, you may enroll online at **DeltaDentalKS.com/Shop**.

	Platinum		Gold		Silver		Bronze	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
Individual*	$71.98	$863.76	$45.32	$543.84	$37.80	$453.60	$32.59	$391.08
Individual +1*	$138.97	$1,667.64	$87.49	$1,049.88	$73.20	$878.40	$65.14	$781.68
Family*	$198.04	$2,376.48	$124.67	$1,496.04	$104.29	$1,251.48	$92.82	$1,113.84

*Delta Dental of Kansas reserves the right to change rates upon the rates being placed on file by the Kansas Insurance Department. Visit DeltaDentalKS.com or call 800.234.3375 to confirm current rates.

Please also complete the back side of this form.

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Please be sure you have completed the front side of this form.

Please carefully read the terms of the Policy incorporated herein by reference, and review the information provided in this application before signing below. **Your signature is required to complete enrollment**.

Agreement Approval

I represent that I am over the age of 18, a legal resident of Kansas and am legally authorized to apply for dental coverage for myself and for all other persons named in this application. I understand that I am making an application for dental coverage offered by Delta Dental of Kansas (DDKS). I understand that I am responsible to pay premium charges to DDKS for this coverage, and if payment is not made when due, my coverage is subject to termination.

I understand that coverage for the dental care policy applied for will not start until after this application and the required monies for premium are received and accepted by DDKS and an effective date is established by DDKS. All complete applications received and processed by DDKS on or before the 25th of the month will be effective the first of the following month (e.g., a January 25th application is effective on February 1st; a January 26th application is effective on March 1st). Rates are guaranteed for 12 months from the effective date of coverage under the policy (e.g., rates for individual plans effective April 1st are guaranteed until March 31st of the following year). I understand that written notice of rate changes will be furnished by DDKS at least sixty (60) days prior to the effective date of any such rate change.

I represent that prior to completing this application, I carefully and fully read it and the policy incorporated herein. I represent that the statements and answers set forth are complete, 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 DDKS 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, DDKS will be entitled to declare the dental care policy applied for void and refuse to provide benefit coverage to any person thereunder.

Refunds will be issued for any month in which a payment was received by DDKS, but due to the termination of the policy or loss of coverage as set forth in Section 2 of the policy, the Enrollee was not entitled to benefits during that month.

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

To cancel coverage, DDKS requires at least a five (5)-day written notice prior to the requested termination date.

I further agree to be legally bound by the terms contained in this application and the terms contained in the policy incorporated herein.

Enrollee Signature: _____ Date: _____

Mail to:

Delta Dental of Kansas
PO Box 3806
Wichita, KS 67201-3806

Broker / Agent Code:

_____
(if applicable)

for internal use only

mailed on:

effective date: