DELTA DENTAL

Application

Mail completed form with payment to:

Delta Dental Insurance Company, Enrollment and Billing Department
P.O. Box 1870
Alpharetta, GA 30023

A. Applicant

Applicants must be 18 and over.

Last Name	First Name	MI
Date of Birth MM/DD/YYYY	Social Security Number	Sex/Gender
Street Address		
City	State	ZIP
Daytime Telephone	Email Address	

B. Dependents

Complete this section if you are enrolling your spouse, domestic partner and/or your dependents.

Relationship	First Name	Last Name	Sex/ Gender	Date of Birth MM/DD/YYYY	Disabled? Yes/No
Spouse/Domestic partner:					
Dependent:					

For assistance in completing this application, call 408 472-9886

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121640-CA_APP #115792 (05/19)

C. Plan Cost and Effective Date Options

Please select your preferred plan option, effective date and billing frequency below.

Plan Option

Select one: ☐ Basic PPO ☐ Premium PPO

Selected effective date (please select when coverage should begin):

☐ 1st of next month

☐ 1st of month after next

Up to 3 business days may be required for processing after the application is received. Thus, if the selected date is not possible, you will be given the next available effective date.

Billing Frequency

If you choose monthly, your initial payment will include your first two months' premium.

Select one: ☐ Monthly ☐ Annually

Plan Cost	Basic PPO		Premium PPO	
Billing Frequency	**Age 18 or older**	**Age 0-17**	**Age 18 or older**	**Age 0-17**
Monthly	$30.58	$25.50	$64.92	$41.75
Annually				

☐ Age 18 or older $ x # _____ $ 0.00

☐ Age 0-17 $ x # _____ $ 0.00

One-time non-refundable Enrollment Fee (required for new enrollment) $ 10.00

Total $ 10.00

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that Delta Dental of California's ratio of health care expense to premiums received for the last calendar year was 56.0%

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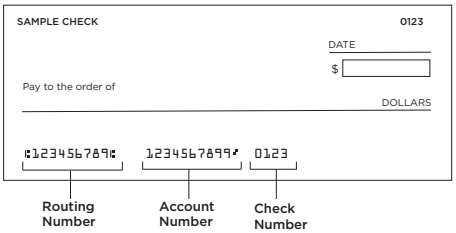
D. Payment Method

Select one:

Use information found on your checks



Direct Payment/Bank Account

Type of Account: ☐ Checking ☐ Savings

Account Holder's Name: _____

Bank Name: _____

Account Number: _____

(do not include check number)

Routing Number (RTN) (9 digits): _____

I hereby authorize Delta Dental, its subsidiaries and affiliates to initiate automatic withdrawal from the account indicated above for the premiums due.

Signature: _____ Date: _____

Credit Card

☐ Visa® ☐ MasterCard® ☐ American Express® ☐ Discover®

Cardholder's Name (as it appears on the card): _____

Credit Card Number: _____

Expiration Date: _____ /_____ CVV Code: _____

(Visa, Mastercard and Discover: last 3 digits on account number panel on back of card. American Express: 4-digit code printed above account number on front of card)

Note: Any credit card refunds may be made by check.

I hereby authorize Delta Dental, its subsidiaries and affiliates to charge my credit card for the premiums due.

Cardholder Signature: _____ Date: _____

Paper Check

☐ Initial Payment ☐ Annual Billing

Check payments are allowed for initial payment or annual billing only. Please make check payable to Delta Dental Insurance Company and include name of primary enrollee in the memo field.

Automatic Recurring Payments (optional)

Sign below to activate automatic payments for future premium payments and policy renewals (only available for Direct Payment or Credit Card).

I understand and agree to authorize recurring payments for premium payments and policy renewals for my dental plan through the Credit Card or Direct Payment method selected above.

I understand that these payments will continue until cancellation is submitted. Cancellations can be submitted by me in writing, by phone or by online request. Delta Dental may cancel recurring payments due to invalid, rejected or returned items. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank. If the electronic recurring payment is canceled upon request by me or by Delta Dental, a new authorization must be completed.

Signature: _____ Date: _____

For assistance in completing this application, call toll-free 1-888-282-8784

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E. Authorization

☐ I understand that you must receive my initial payment by the effective date for coverage to begin.

☐ Go Paperless. I have read the Electronic Delivery Terms and Conditions (below) and I wish to receive my policy and all related policy documents electronically when available.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Applicant Signature: _____ Date: _____

Mail completed form with payment to:

Delta Dental Insurance Company, Enrollment
C/O John Powers 286 Calero Ave San Jose, Ca 95123

F. Agent/Producer Information

Applicable for Agent/Producer only

Name	Agent/Producer License Number
Delta Dental Insurance Company Agent/Producer Number	
Email Address	
Phone Number	Phone Number Type Mobile/Home/Business/Other
Signature	Date

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G. Electronic Documents Terms and Conditions

1. **Communication Methods:** All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental website with your username and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing."

   You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.

2. **Types of Documents that Will Be Electronically Communicated:** Documents available electronically include, but are not limited to: your application status, your dependent(s) application status, your billing statements, your payment method, your Policy and your claims information.

3. **Requesting Paper Copies:** You can obtain a paper copy of any electronic document by printing it yourself or by requesting that we mail you a paper copy. To request a paper copy, contact our Customer Service Center. There is no charge associated with requesting a paper copy of a communication we send to you electronically.

4. **How to Withdraw Consent:** You may withdraw your consent to transact business electronically by indicating your preference at our website or by contacting our Customer Service Center without any charge. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.

5. **How to Update Your Records:** It is your responsibility to provide us with a true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information at our website or by contacting our Customer Service Center.

6. **Hardware and Software Requirements**: In order to access, view, sign and retain electronic documents that we make available to you, you must:
   - Have a device that will connect to the Internet, access to an email account and access to an Internet browser.
   - Access to Adobe® products will not be required to electronically sign forms but may be necessary to view, download or print documents.
   - Be able to view the disclosures on your device.
   - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.