



Enrollment or Update Form for: Individual and Family Dental Plans

Enroll online now at www.DeltaDentalMN.org/shop/ or complete this application 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

This section must be completed for us to process your enrollment or update your records. **Please print clearly.**

Subscriber Name (First) <input type="text"/> Birth Date <input type="text"/> <input type="text"/> <input type="text"/> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Street Address <input type="text"/> City <input type="text"/> Email Address (Optional) <input type="text"/> New Coverage / Change / Termination Effective Date * <input type="text"/> - <input type="text"/> - <input type="text"/> <small>(Requested date of new coverage, change in coverage or termination)</small>	(M.I.) <input type="text"/>	(Last) <input type="text"/> Subscriber Social Security Number - Requested but not required <input type="text"/> - <input type="text"/> - <input type="text"/> State <input type="text"/> ZIP Code <input type="text"/> - <input type="text"/> Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/> *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 _____
Example ABCDEF123456 Check here if this is a new address		

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.)		
Spouse Name (First) <input type="text"/> Birth Date <input type="text"/> <input type="text"/> <input type="text"/> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	(M.I.) <input type="text"/>	(Last) <input type="text"/>

Dependent Child Information #1		
Dependent Child Name (First) <input type="text"/> Birth Date <input type="text"/> <input type="text"/> <input type="text"/> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	(M.I.) <input type="text"/>	(Last) <input type="text"/>

Dependent Child Information Continued: #2

Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

#3 - Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

#4 - Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

#5 - Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Male Female

For additional dependents, please provide complete information on a separate piece of paper and include with this form.

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 FamilySM - Plan A (\$50 Deductible/\$1,500 Annual Plan Maximum)
- Delta Dental Individual and FamilySM - Plan B (\$100 Deductible/\$1,200 Annual Plan Maximum)
- Delta Dental Individual and FamilySM - Plan C (\$100 Deductible/\$750 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

[Grid for Street Address]

City

[Grid for City]

State

[Grid for State]

ZIP Code

[Grid for ZIP Code]

[Grid for ZIP Extension]

I hereby authorize Delta Dental of Minnesota, its subsidiaries, and its affiliates to charge my credit card for premiums due. This authorization will remain in effect until Delta Dental of Minnesota has received written notice from me of its termination. If the billing amount changes, Delta Dental of Minnesota or Health Ventures Network, if applicable, will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature _____

Date _____

John J. Doe	1-1983	1234
Jane K. Doe		
4321 Main St.		
Anytown, MN 45678		
Pay to the order of _____	\$ _____	
		DOLLARS
XYZ Bank		
For _____		MP
!01 0123456!	987654321011"	1234

Automatic withdrawal from bank account

Routing number Account number

Bank Name

[Grid for Bank Name]

Checking Account

Routing Number

Account Number

Savings Account

[Grid for Routing Number]

[Grid for Account Number]

I hereby authorize Delta Dental of Minnesota, its subsidiaries, and its affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental of Minnesota 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 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.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ForeignLanguageNotifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-643-3582 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-643-3582 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-643-3582 (TTY: 711). (Cushite)

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)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-643-3582 (TTY : 711)。 (Chinese) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-643-3582 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ ສຽງຄຳ, ຄຸ້ມ ນຸມ ໂອນໃຫ້ທ່ານ. ໂທ 1-855-643-3582 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩትን ቋንቋ አማርኛ ከሆነ የትርጉም አገልግሎቶችን የጸሊያ ለማግኘት ተዘጋጅተው ለመገኘት 1-855-643-3582 (መስማት ለተሳናቸው: 711). (Amharic)

1-855-643-3582 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-643-3582 (TTY: 711). (German)

1- 855- 643- 3582 مقرب لصتا. ناچملاب كل رفاوتت ةيوغلا ةدعاسملا تامدخ نإف، ةغلا ركذا ئدحتت تنك اذا: ةظوحلم ه مصلا مكبلارو. (Arabic) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Appelez le 1-855-643-3582 (ATS : 711). (French)

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

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)

هتسهدرهب. (Kurdish) یراداکای: رهگهئ هب ینامز یدروک هسهق تیهکهد، یناکهیرازوگتھمزخ یتهمرای نامز، بیارۆخهب، ۆب ۆت هکب. (TTY: 711) 1-855-643-3582

هجوت: رگا هب نابز یسراف وگتفگ یم دینک، تالیهست ینابز تروصب ناگیار یارب امش. دیریگب اب. دشاب یم ف (TTY: 711) سامت (Persian / Farsi) 1-855-643-3582

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 (TY: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. Woterefona 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 språkassistenttjenester tilgjengelige for deg. Ring 1-855-643-3582 (TTY: 711). (Norwegian)

ស ម ្រ ង ប យ ក ៖ រ ូ ប ស ័ ប អ ្រ ក ័ យ [០០ ០៩១៧], ០ស០៥ ៩ យ ០០ ០០យកកក ក៧០, ០ដលអ្រក្រ រ ០ រ ០ ប ០ ស ០ ៩ ៧ ម ០ ៩ រ ៧ ០ ៧ ០ 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

धयनकषण : यद तप [नप ल] ब लनहनछ भन, नःशलक पम तप लई भष सहयत सवह उपलबध छन 1-855-643-3582 (TTY: 711) (Nepali)