



Delta Dental of Arizona
P.O. Box 43000, Phoenix, AZ 85080-3000
Phone (602) 938-3131 — (800)-352-6132

**Enrollment /
Change of Status Form**

Please Print Using Black Ink – Press Firmly – Multiple Copies

SECTION A: QUALIFYING EVENT (Member Please ✓ One)

New Enrollment. (Complete All Sections)
 Add/Delete/Dependents(s): Indicate Date of Qualifying Event (Complete Section B, C)
Marriage: _____ Birth: _____
Divorce: _____ Adoption: _____
Other: _____
 Address Change Decline Coverage (Complete Sections B, E)
 Name Change
To: _____
From: _____

FOR DELTA USE ONLY

Group #: _____
Eff. Date: _____ Wait Start Date: _____
Rate Code: _____

SECTION B: APPLICANT INFORMATION

Social Security Number

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 Marital Status Single Married Gender M F
Date of Birth _____/_____/_____
Date of Hire _____/_____/_____
Applicant's Last Name _____ First _____ Middle Initial _____ Home Telephone _____
Home Address (Mailing) _____ City _____ State _____ Zip Code _____
Email Address _____ Employer _____ Position/Title _____ Realtor Association Member Number _____

SECTION C: DEPENDENT INFORMATION* see below for definition of eligible dependents

Add	Chg	Del	Last Name (if different) First, M.I.	Social Security Number	Relationship to Applicant	Gender (M/F)	Date of Birth	Full-Time Student	
								Yes	No

*Eligible Dependents: Your lawful spouse, unmarried children under age 19 or 23 if full-time student, or those your lawful spouse, including newborn children, stepchildren, disabled children, persons under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption with you in accordance with applicable state or federal law. Verification of dependent status for children over age 19 may be required.

SECTION D: PLAN SELECTION / PAYMENT OPTIONS

<u>Choose Your Plan</u> See Summary of Benefits for Plan descriptions				<u>Choose Billing Options</u> Choose one- mark selection with an "X"	
Coverage	<u>Plan 1- Premium</u> Choose Coverage- Mark selection with an "X"	<u>Plan 2- Premium</u> Choose Coverage- Mark selection with an "X"	<u>Plan 3- Premium</u> Choose Coverage- Mark selection with an "X"	<u>Monthly EFT</u> _____	<u>Annually by Check</u> _____
Single*	\$49.27	\$39.83	\$25.62	<u>Billing Calculation</u> Monthly Premium: _____ x 3 months: _____ One-Time Application Fee + \$15.00	<u>Billing Calculation</u> Monthly Premium: _____ x 12 months: _____ One-Time Application Fee + \$15.00
Single + 1 dependent**	\$91.09	\$71.59	\$47.36	Total Down Payment _____	Total Down Payment _____
Single + 2 or more dependents***	\$158.95	\$125.81	\$82.66	*Your Total Down Payment and completed EFT Authorization Form must be included with your enrollment form.	*Your Total Payment must be included with your enrollment form

* Single coverage only covers you
** Single + 1 dependent coverage includes you and only one qualified dependent
*** Single + 2 or more dependents coverage includes you and multiple qualified dependents

SECTION E: AUTHORIZATION

I hereby apply for membership with Delta Dental of Arizona, Inc. pursuant to the terms specified on Page 2 of this form, which are hereby incorporated by reference. By signing below I declare I am a resident in the State of Arizona and agree to have all benefit materials delivered to me electronically as allowed by law.

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Applicant's Signature / Authorization Social Security Number Date Signed

I hereby apply for membership with Delta Dental of Arizona, Inc. (Delta Dental) and I understand and agree that my coverage, and that of any dependents, will become effective on the date established by my dental coverage policy (referred to as "Plan"). I agree to be bound by the provisions of the Plan. Any dependents that are later added to my Plan will have different effective dates.

I understand that enrollments are for consecutive 12-month period(s) and my premium is subject to change on the annual anniversary date. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period.

I am responsible to notify Delta Dental upon any change that would make me or any dependent ineligible for coverage.

I will cooperate with Delta Dental and furnish all information requested to enforce its right to coordinate benefits.

I hereby authorize any physician, dentist, hospital, or insurer having records of information concerning health history or other insurance for me and those persons specified as dependents to furnish such records, data, or information as may be requested by Delta Dental or their duly authorized representative to review eligibility, determine benefits (if any), contract administration, detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. I hereby authorize Delta Dental to release information related to my benefits and those persons specified as dependents benefits under this plan to any dental office. I understand that this authorization is valid for a minimum of 12 consecutive months from the date signed and/or the latest renewal during the open enrollment period. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I, or any authorized representative may receive, upon request, a copy of this authorization. This information may also be given by Delta Dental to its legal representatives.

To the extent allowed by law, Delta Dental is authorized to furnish all information and copies of records requested by other insurers, dental plans or other parties for the purposes of determining eligibility for coverage or benefits, coordinating benefits, utilization review or audit.

Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this application, the identification card and the dental coverage policy will constitute the contract.

Uses and Disclosures of Health Information: At Delta Dental, we use health information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the dental coverage policy and to perform assurance. We NEVER sell any information we collect while processing transactions on your request. You can be assured that when processing or servicing a transaction at your request, only the minimum necessary information regarding your account or personal history information will be used or disclosed, as permitted by law. Delta does not routinely record the identity of the recipient of the information that we have disclosed to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the dental coverage policy and to perform quality assurance. For more information about our privacy practices, please visit www.deltadentalaz.com under privacy policy or contact Customer Service, Phone: (602) 938-3131 or (800) 352-6132, Email: customerservice@deltadentalaz.com.