DELTA DENTAL®

PLEASE TYPE OR PRINT IN BLACK INK
APPLICATION MUST BE COMPLETED IN FULL

Delta Dental Individual & Family™ Dental/Vision Plan Application

Please send completed application to:
Delta Dental of Arizona
Attn: Individual Plan Unit
PO Box 1950
Indianapolis, IN 46206
Fax: 888.984.7161

Sales or Enrollment Questions:
800.894.2701
indsales@smilepoweraz.com

Existing Member Change of Status Questions:
800.894.2961
service@smilepoweraz.com

SECTION 1: Policyholder Information

Last Name	First Name	Middle Initial	Social Security Number
Home Address (Mailing)			
City	State	Zip	Phone
Email Address*	Date of Birth	Marital Status: ☐ Single ☐ Married	

**By providing my email address, I agree to receive communications regarding my Policy and benefits electronically. For more information about your rights, see www.smilepoweraz.com.*

Employment Status: ☐ Employed ☐ Self-employed ☐ Retired ☐ Not Currently Working

Reason for Application ☐ New Enrollment ☐ Change of Dependent(s) ☐ Add DeltaVision® Upon Renewal

SECTION 2: Dental Plan Selection

Select your plan:
☐ Mesquite Plan-762 ☐ Saguaro Plan-763 ☐ Agave Plan-764
☐ Cholla Plan-765 ☐ Copper Plan-766 ☐ Turquoise Plan-767

SECTION 3: Vision Plan Selection

DeltaVision® is an optional add-on to your dental plan. If selected, all persons covered on the dental plan will also be covered on the vision plan.

Select your plan: ☐ Vision Plan-100 ☐ Decline Vision Coverage

SECTION 4: Covered Persons (Policyholder must be a covered person. List policyholder first.)

First Name	Last Name	Date of Birth	Relationship to Policyholder (Self, Spouse or Dependent)	Gender	Disabled Child (Y/N)
		____/____/____ MM DD YYYY			
		____/____/____ MM DD YYYY			
		____/____/____ MM DD YYYY			
		____/____/____ MM DD YYYY			
		____/____/____ MM DD YYYY			

Were the above persons covered by a dental plan in the past 63 days? ☐ Yes ☐ No

Previous Insurance Company Name	Beginning Date of Coverage	Ending Date of Coverage
	_____/_____/_____ (MM/DD/YYYY)	_____/_____/_____ (MM/DD/YYYY)

FORM CONTINUES TO NEXT PAGE.

SECTION 5: Payment Method

A debit/credit card or Electronic Funds Transfer (EFT) may be used to pay monthly or annually. If paying by check, remittance for the full annual 12-month premium is required and is payable to Delta Dental of Arizona. If you need help calculating this amount, call 800.894.2701. Rates are also available on www.smilepoweraz.com.

Applications must be received by the last day of the month if requesting a 1st of the following month effective date. If the application is late, your effective date will be adjusted to the 1st of the next month.

Choose payment method: ☐ Debit/Credit Card ☐ EFT ☐ Annual Check

Please complete the following information for payment by debit/credit card:		
Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express	Cardholder Name	
Cardholder Mailing Address (if different than Policyholder)		
City	State	Zip Code
Card Number	Expiration Date _____/_____ (MM/YYYY)	Security Code (from back of card)
Payment Frequency: ☐ Monthly ☐ Annually		

Please complete the following information for payment by EFT:	
Name of Financial Institution	Financial Institution's City, State & Zip Code
Type of Account: ☐ Checking ☐ Savings	Name on Account
Bank Routing Number	Bank Account Number

I authorize Delta Dental of Arizona to initiate debit entries from my above bank account or debit/credit card for my plan premiums. This authority is to remain in full force and effect until Delta Dental has received written notification from me of its termination in such time and in such manner to afford Delta Dental of Arizona and my financial institution a reasonable opportunity to act upon it. In addition, I have confirmed that the information provided is correct. This includes correct spelling, capitalization and punctuation.

I understand that initial payment is drafted around the 5th of the month in which my plan becomes effective. If the charge is declined for any reason, I understand that a hold will be placed on my account and dental claims may be denied. If subsequent attempts to collect payment fail, Delta Dental of Arizona will terminate my contract for nonpayment, effective as of the last day of the grace period.

_____ _____/_____/_____
Signature Date Signed (MM/DD/YYYY)

SECTION 6: Authorization

In submitting this application to Delta Dental of Arizona for individual coverage, I agree and understand that this application will become part of the Policy and I agree to be bound by the terms of the Policy issued by Delta Dental of Arizona. I understand that this is a contract under which I am obligated to pay premium for the term of the contract. I further agree that the coverage requested is subject to the approval of Delta Dental of Arizona and that no representative has authority to make changes or modify this application for coverage.

I certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Policy to be null and void. In the event it is discovered that I have provided false or misleading information in connection with this application for the purpose of defrauding Delta Dental of Arizona, Delta Dental shall inform the appropriate state and regulatory authorities, including, but not limited to, my state's insurance commissioner. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

By my submission of this application I attest that I do not have other active individual dental coverage. If at any time I obtain other individual dental coverage, Delta Dental of Arizona reserves the right to terminate this plan with 30 days notice.

The Policy will become effective on the first day of the month following approval of this application.

_____ _____/_____/_____
Policyholder Signature Date Signed (MM/DD/YYYY)

Agency Use Only

Agency Name	Agent Name	Agent NPN

Policies are underwritten by Arizona Dental Insurance Service Inc. dba Delta Dental of Arizona. All dental and vision policies are administered, at least in part, by Renaissance Life & Health Insurance Company of America, Inc. and First American Administrators, Inc. Certain network administration services are provided through EyeMed Vision Care, LLC.