DELTA DENTAL

Delta Dental Individual & Family Enrollment Form

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
(800) 627-3961 Fax (605) 224-0909
www.deltadentalsd.com

☐ Prevent #1031
☐ Restore #1041
☐ Renew #1051

Requested effective date _____. Must be the first of the month. Generally, your effective date will be the first of the month following receipt of your completed enrollment form.

Subscriber Information

First name _____ Last name _____

Mailing address _____ City _____ Zip _____

Social Security Number _____ Date of birth _____ Gender ☐ M ☐ F

Cell phone* _____ Email* _____

Type of coverage you are applying for:

☐ Single ☐ Two People ☐ Three or More People

Covered Dependents (child to age 19 or 26 if an unmarried full-time student)
List all covered dependents you are enrolling. If additional space is required, attach a list to this form.

	First Name	Last Name	Date of Birth	Gender
Spouse				☐ M ☐ F
	Cell phone*	Email*		
Dependent				☐ M ☐ F
	Cell phone*	Email*		
Dependent				☐ M ☐ F
	Cell phone*	Email*		
Dependent				☐ M ☐ F
	Cell phone*	Email*		
Dependent				☐ M ☐ F
	Cell phone*	Email*		

*I consent to Delta Dental using this contact information for quality improvement activities (e.g. surveys) for individuals over the age of 18. Email and text messages sent from Delta Dental may not be sent in an encrypted or secure manner.

☐ Check here if you have been continuously covered under another dental plan for at least the last 12 months.

Insurance carrier _____; policy number _____;

and dates of coverage _____ to _____.

Payment Method

Option 1: Monthly electronic funds transfer – *A voided check or letter from your bank must be attached. Upon receipt of this form, Delta Dental will withdraw the initial payment from your account. Thereafter, we will withdraw on or after the 21st of the month for the following month. Monthly withdrawals will continue until we receive written notice that you want to cancel your coverage.*

Name of financial institution _____

Financial institution's city, state & zip _____

Type of account: ☐ Checking ☐ Savings

Name on account _____

Bank routing number _____ Bank account number _____

Option 2: Monthly credit card charge - *Upon receipt of this form, Delta Dental will charge your credit card for the initial payment. Thereafter, your credit card will be charged on or after the 21st of the month for the following month.*

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Name on card _____

Card number _____

Expiration date: month _____ year _____

Option 3: Annual check *(Include your check with this form.)*

Correspondence

NOTICE – All correspondence regarding this policy will be sent electronically unless you request to be contacted by mail. Correspondence will be sent to the email address listed at the top of this application. You must maintain a valid email address to ensure delivery and receipt of information regarding your plan. We will not send private health information in an email.

☐ Check here if you prefer to receive correspondence by mail.

Enrollee Signature _____ Date _____

Agreement

I certify the information contained in this application is true and complete to the best of my knowledge. I understand that misrepresentation of submitted data may cause this application and subsequent policy to be null and void. I further understand that covered services are eligible for payment only if my Agreement is in effect at the time the services are provided. I understand that notice of rate changes will be provided by Delta Dental of South Dakota at least 45 days before the rates change.

I authorize Delta Dental of South Dakota to access my credit card or conduct an electronic funds transfer (EFT) of my designated bank account until further notice for payment of my premiums. Regardless of the payment method, I understand that my enrollment is subject to Delta Dental approving my application and receiving payment. If funds are not available or payment is not made on time, I (and my dependents) will no longer be eligible for coverage. I also understand that if I terminate my policy, I will not be able to re-enroll for two years.

FOR AGENT USE ONLY

Printed Name: _____ Phone _____

Agent Signature: _____ Date _____