Delta Dental Individual and Family Plans Enrollment Form

(1040) ☐

ACA Standard Option (502) ☐

ACA Enhanced Option (503) ☐

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

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

Phone Number _____ E-mail Address _____

Please check the type of coverage you are applying for:

1040 Plan	**502/503 Plans**	
☐Individual	☐Individual	☐Couple
☐Two Person	☐ Individual +1 Dep	☐ Couple +1 Dep
☐Family	☐ Individual + 2 Dep	☐ Couple + 2 Dep
	☐ Individual + 3+ Dep	☐ Couple + 3+ Dep

Covered Dependents

List all covered dependents you are enrolling. If additional space is required, attach a list to this form.

	Last Name	First Name	Date of Birth	Gender
Spouse				☐M ☐F
Dependent				☐M ☐F
Dependent				☐M ☐F
Dependent				☐M ☐F
Dependent				☐M ☐F

Dependent children on the 1040 plan are covered through the end of the month in which they turn 19 unless they are an unmarried full time student. Dependent children on the 502/503 plans are covered through the end of the month in which they turn 26.

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

Please list insurance carrier _____; policy number _____;

and dates of coverage _____ to _____.

Payment Method

Option 1: Monthly electronic funds transfer - *A voided check must accompany this form. Upon receipt of this form, Delta Dental will withdraw the initial payment from your account. Thereafter, Delta Dental will withdraw from your account on or after the 5th of each month for the 1040 plan or the 20th of each month for the 502/503 plans. The withdrawal will be for the following month (e.g. February premium will be drawn in January). Monthly automatic withdrawals will continue until we receive written notice from you that you want to cancel your coverage.*

Name of Financial Institution _____

Financial Institution's City, State & Zip Code _____

Type of Account (choose one) ☐ 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 5th of the month for the 1040 plan or the 20th of the month for the 502/503 plans. The withdrawal will be for the following month (e.g. February premium will be drawn in January).*

Card Type ☐ Visa ☐ MasterCard ☐ Discover

Name on Card _____

Card Number _____

Expiration Date _____month _____year

Option 3: Monthly check *(Only available on the 502/503 plans. Please include your check with this form.)*

Option 4: Annual check *(Only available on the 1040 plan. Please include your check with this form.)*

Agreement Approval

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 are changed.

I authorize Delta Dental of South Dakota to access my credit card or conduct an electronic funds transfer (EFT) of my designated personal bank account until further notice for payment of my premiums. If I do not choose either the credit card or EFT options, I will make payment by personal check, in advance, each month. Regardless of the payment method, I understand that my enrollment is subject to Delta Dental approving my application and receiving my payment and 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.

Enrollee Signature _____ Date _____

Correspondence

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

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

Your Individual and Family policy, which explains how to use your plan and lists additional descriptions, terminology and coverage issues, can be downloaded from the Delta Dental website at www.deltadentalsd.com.

☐ *Check here if you prefer to receive a copy of your policy by mail.*

FOR AGENT USE ONLY

Printed Name: _____ Phone _____

Agent Signature: _____ Date _____

Required Nondiscrimination and Accessibility Statement*

Discrimination is Against the Law

Delta Dental of South Dakota 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 South Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of South Dakota:

- 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).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters;
  - Information written in other languages.

If you need these services, call 1-877-841-1478.

If you believe Delta Dental of South Dakota 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 with: Delta Dental of South Dakota, Compliance Manager, 720 N. Euclid Ave., Pierre, SD 57501, phone: 1-800-627-3961, compliance@deltadentalsd.com , fax: 1-605-224-0909, TTY: 1-888-781-4262. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Manager is available to help you.

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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-841-1478 (TTY: 1-888-781-4262).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-841-1478 (TTY: 1-888-781-4262).

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 1-877-841-1478（TTY：1-888-781-4262）。

ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤ ကညီ ကျိာ်အဃိ.
နမၤနှ့ၢ် ကျိာ်အတ်ါမၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၢ
နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိ 1-877-841-1478 (TTY: 1-800-874-9426)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-841-1478 (TTY: 1-888-781-4262).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877-841-1478 (टिटिवाइ: 1-888-781-4262) ।

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-841-1478 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-781-4262).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-841-1478 (መስማት ለተሳናቸው: 1-888-781-4262).

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-877-841-1478 (TTY: 1-888-781-4262).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-841-1478 (TTY: 1-888-781-4262).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-841-1478 (TTY: 1-888-781-4262) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-841-1478 (телетайп: 1-888-781-4262).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-841-1478 (TTY: 1-888-781-4262).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-841-1478 (телетайп: 1-888-781-4262).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-841-1478 (ATS : 1-888-781-4262).

* Under Section 1557 of the Affordable Care Act (ACA), Delta Dental of South Dakota is required to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency (LEP) to the availability of language assistance services.

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