DELTA DENTAL®

Please send completed application to:
Consumer Direct Team
P.O. Box 3384
Lisle, IL 60532
Fax (630) 369-0507
individual@deltadentalil.com

Application for Individual Dental Insurance

PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL

Consumer Direct Department: 877-824-2776

Last Name	First Name	Middle Initial	Gender: M/F

Home Address (Mailing)	City	State	Zip

Phone No. (with area code)	E-mail Address	Date of Birth	Marital Status: Single/Married/ Divorced/Widowed/Separated

Reason for Application: ☐ Initial Application ☐ Change of Dependent(s) ☐ Change in Enrollment (Single/Family Plan)

Please let us know how you heard about Delta Dental of Illinois' Individual Dental Product:
☐ Dentist Office ☐ Delta Dental of Illinois' website ☐ Friend/Family ☐ Advertisement ☐ Broker ☐ Other _____

Select Plan:
☐ Kids Dental Wellness Plus ☐ Gold ☐ Gold with Kids Dental Wellness Plus ☐ Silver ☐ Silver with Kids Dental Wellness Plus ☐ Bronze

Monthly Rate:	Kids Dental Wellness Plus	Select Type of Coverage:	Monthly Rates:	Gold	Gold with Kids Dental Wellness Plus	Silver	Silver with Kids Dental Wellness Plus	Bronze
Per Person under age 19	$_____	☐ Single ☐ Two-Person ☐ Family- (Three or more persons)	Single	$_____		$_____		$_____
			Two-Person	$_____	$_____	$_____	$_____	$_____
			Family	$_____	$_____	$_____	$_____	$_____

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY

First Name	Last Name (If different from Applicant)	Date of Birth	Relationship to Applicant	Gender: M/F

CHANGE OF COVERAGE: Please check events requiring Contract changes

☐ Add Dependent due to: ☐ Birth ☐ Adoption ☐ Marriage ☐ Legal Guardianship ☐ Handicapped Dependent
☐ Drop Dependent (list below) due to: ☐ Age ☐ Death ☐ Other Coverage Elsewhere
☐ Name Change (Former Name:_____) ☐ Address Change ☐ Change in Enrollment (Single/Family Plan)

PRIOR DELTA DENTAL COVERAGE Were any of the above enrollees covered by a Delta Dental of Illinois employer-sponsored group plan within the past 60 days? ☐ Yes ☐ No

If yes, please provide the names of those enrollees:

_____ _____

_____ _____

_____ _____

Delta Dental of Illinois will verify previous coverage of enrollees. Upon validation, benefit waiting periods may be waived.

PAYMENT INSTRUCTIONS:

Choose your payment method: ☐ Bank Account ☐ Credit Card

Payment options: ☐ Annual ☐ Monthly

If you choose bank account as your method of payment, payment is made by electronic funds transfer (EFT). For verification purposes, please attach a voided check to this application. The charge to your credit card/deduction from your bank account for the first month will occur immediately. Ongoing monthly premiums will be charged/deducted on the 27th of the month.

Please complete the following information for payment by bank account:

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 _____

For verification purposes, please attach a voided check to this application.

Please complete the following information for payment by Credit Card:

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on Card: _____

Card Number: _____

Expiration Date: _____ month _____ year Security Code: _____

Billing Address of the Cardholder if different from the address of the applicant: _____

I hereby authorize Delta Dental of Illinois to withdraw funds from the bank account or debit my credit card listed above for the payment of my dental insurance premiums.

Signed: _____ Date: _____

I understand that any transaction that is dishonored by my bank/credit card intended for payment to Delta Dental, may be assessed a $25.00 service charge by Delta Dental of Illinois.

In making this application to Delta Dental of Illinois (DDIL), for dental coverage under this program, 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 DDIL. I further agree that the coverage requested is subject to the approval of DDIL and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

By my submission of this application, I attest that I am a resident of Illinois and not covered by any other dental benefit program.

Applications must be received by the 20th of the month to be effective the 1st of the following month. Applications received after the 20th will be effective the first of the month after the next month.

_____ _____

Applicant Signature Date

A parent/guardian signature is required for applicants who are under 18 years of age.

_____ _____

Parent/Guardian Name Relation to the Applicant

_____ _____

Parent/Guardian Signature Date

Coverage is contingent upon underwriting acceptance

FOR BROKER USE ONLY GENERAL AGENCY: EUCLID MANAGERS

Broker ID: _____

Broker/Agency Name: _____

Broker Email: _____

Note to brokers:

For commission to be paid accurately, it is vital that you enter the correct agency code assigned to you by Delta Dental of Illinois in the space indicated. If you are not sure of the agency code that has been assigned to you, contact your Delta Dental sales representative before submitting this application.