Application and Change Form for Individual & Family Dental Insurance

P.O. Box 981400
Boston, Massachusetts 02298-1400

Customer Service: (800) 872-0500
www.deltadentalma.com/dental_plans/individual.asp

Please print or type. Required fields are starred (*) and must be completed to ensure enrollment. Subscriber must be age 18 or older.

1. * LAST NAME: (Subscriber)		2. *FIRST NAME:	
3. * SOCIAL SECURITY NO.:	4. *DATE OF BIRTH:	5. *GENDER: F / M	
6. * HOME ADDRESS:	7. *CITY:	8. *STATE:	9. *ZIP:
10. * COUNTY:	11. *PHONE NUMBER:	12. *E-MAIL:	

ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY

If you are applying for **Subscriber Only** coverage, do not complete this section.

13. FIRST NAME	14. LAST NAME (if different from subscriber)	15. DATE OF BIRTH
SPOUSE		
CHILDREN		

16. Are you a former Delta Dental of Massachusetts member through an Employer plan or COBRA? ☐ No ☐ Yes

If yes, please provide former subscriber ID Number ______________ Last Date of Coverage ______________

REASON FOR SUBMISSION

17. * CHECK ONE:

☐ New Application ☐ Reinstatement ☐ Termination ☐ Change

IF TERMINATION OR CHANGE, PLEASE COMPLETE BELOW (CHECK ALL THAT APPLY):

☐ Name ______________ Phone Number ______________

☐ Address ______________ Email ______________

☐ Coverage to: ☐ Subscriber Only ☐ Subscriber+One ☐ Family

☐ Add dependent(s) Name ______________ Name ______________

☐ Remove dependent(s) Name ______________ Name ______________

Please use a separate page for additional dependents to be added or removed from plan.

If changing plans indicate the new selection: ☐ Option 1 ☐ Option 2

☐ Payment method (You must complete section 20)

Termination (Reason):

☐ Relocated out of Massachusetts ☐ Have other Dental Plan ☐ Other ______________ ☐ Non-payment ☐ Deceased

DELTA DENTAL PREMIER PLAN SELECTION

Please refer to the Summary Plan description to review your options

18. *SELECT ONE: ☐ Option 1 ☐ Option 2

19. *SELECT ONE: ☐ Age 50 and older ☐ Under age 50

To complete this application, you must select one payment option in section 20 and sign section 21 on side 2, and mail items to Delta Dental, C/O Crosby Benefit Systems, P.O. Box 981400, Boston, MA 02298-1400

PAYMENT INSTRUCTIONS

20. *SELECT ONE PAYMENT METHOD AND FOLLOW INSTRUCTIONS:
Please see enclosed rates or visit www.deltadentalma.com/dental_plans/individual.asp. Premiums are due by the 20th of each month, prior to the month of coverage.

PAYMENT METHOD 1

☐ **AUTOMATIC MONTHLY WITHDRAWAL FROM BANK ACCOUNT (AUTOMATED CLEARING HOUSE (ACH) PAYMENTS)**

Please select coverage:

☐ Subscriber Only $ ______________

☐ Subscriber + One $ ______________

☐ Family $ ______________

ACH payments occur on the 20th of the month (or next business day) prior to coverage. Please make your first payment by check payable to Delta Dental of Massachusetts. Enclose it with this application and postmark it by the 20th of the month for coverage effective the first day of next month. You must sign the Authorization Agreement and attach a voided check to this application. All future payments will then be deducted from the bank account indicated below by Crosby Benefit Systems, Inc.

AUTHORIZATION AGREEMENT FOR ACH PAYMENTS

I authorize Crosby Benefit Systems, Inc., agent for Delta Dental of Massachusetts, hereafter named the COMPANY, to initiate recurring monthly debit or credit entries to my (Checking Account / Savings Account) as indicated and named below as the depository financial institution, hereafter named FINANCIAL INSTITUTION. I acknowledge that the origination of ACH transactions to my account must comply with the U.S. law. If any such debit(s) is returned Non-Sufficient Funds, I authorize the COMPANY to collect that amount along with a Non-Sufficient Funds fee of $25.00 per item by electronic debit from my account.

I am an authorized check signer on the account listed below, and authorize all of the above as evidenced by my signature below.

Financial Institution ______________ Branch ______________ City ______________

State ______________ Zip ______________ Routing Number ______________ Acct. Number ______________

This authorization is to remain in effect until the COMPANY has received written notification from me of its termination with 30 days notice.

Name ______________ Signature ______________ Date ______________

PAYMENT METHOD 2

☐ **MONTHLY PREMIUM PAYABLE BY CHECK**

Please select coverage:

☐ Subscriber Only $ ______________

☐ Subscriber + One $ ______________

☐ Family $ ______________

Make check payable to Delta Dental of Massachusetts with this Application and postmark it by the 20th of the month for coverage effective the first day of the following month. In the event there are not sufficient funds to cover my check, I agree to pay a $25 Non-Sufficient Funds fee.

Name ______________ Signature ______________ Date ______________

COVERAGE PERIOD

The initial term of your policy will be for one year from the Effective Date. After the initial term, this policy will renew automatically establishing a new Effective Date each year until a Change Form is submitted or until this Agreement is terminated. This policy may be terminated upon thirty (30) days written notice to Delta Dental of Massachusetts. Additionally, you must wait at least one year after your cancellation before you can enroll again as a subscriber.

Delta Dental reserves the right to change premium rates upon renewal of the policy. Delta Dental agrees to keep your coverage in force as long as you continue to pay the premiums on time and as long as you retain residency in the state of Massachusetts.

Applications postmarked by the 20th of the month will become effective the 1st of the following month. Examples: Applications postmarked June 20 will have an Effective Date of July 1. Applications postmarked June 21 will have an Effective Date of August 1.

TERMS

By signing below, you verify that you have read and agree to the following:

- **I UNDERSTAND THAT THERE IS A SIX MONTH WAITING PERIOD ON BASIC RESTORATIVE SERVICES AND A TWELVE MONTH WAITING PERIOD ON MAJOR RESTORATIVE SERVICES. (May be waived for previous Delta Dental of Massachusetts group members who have no more than a 60 day break in coverage.)**
- I confirm that all information is true and correct to the best of my knowledge.

NOTICE: Any person who purposely attempts to commit fraud or deceive an insurer by filing a false claim or an application with false, incomplete or missing information is guilty of a third degree felony and will result in this policy being terminated.

21. *Subscriber Signature ______________ Date ______________

22. Will this policy replace an active dental insurance policy? ☐ No ☐ Yes (If Yes, please complete the Notice of Information Practices form and include it with this application)

Notice of Information Practices

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

Replacement Form

If you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Delta Dental you must sign and return this form with your application. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right, under the policy you have chosen.

The above “Notice to Applicant” was delivered to me on:

____

Date

____

Signature of applicant

____

Printed name of applicant