



Small Group Dental Enrollment / Change Application

TeamService@DeltaDentalia.com
www.deltadentalia.com
Fax: 1-888-558-9212
Phone: 1-877-983-3582

Group Number (Completed by Employer)	Effective Date (Completed by Employer) ____/____/____
<input type="checkbox"/> New Applicant <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name/Address Change	Dept/EE Number

SECTION I	Name (First, Middle Initial, Last)	Social Security Number	Telephone () ()
Mailing Address – Street	City	State	Zip
Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other (specify) _____			Hire Date / /
Employer Name		Employer Location	

SECTION II ELIGIBLE MEMBERS ELECTING COVERAGE

List self and eligible members to be covered	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
First Name Middle Initial Last (if different)						
Self		___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes
Spouse		___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child		___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child		___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child		___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Other Dental Coverage - If any person(s) on this application has other dental insurance please complete.
Contract holder: _____
 _____ / ____ / ____ **Single** **Family**
Name of Other Dental Carrier _____ **Policy Number** _____ **Effective Date** _____ **Contract type** _____

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes:
 Marriage Death Divorce Birth/Adoption Drop Covered Person COBRA Terminating Benefits
 Other (explain) _____ **Name of Affected Party** _____ **Date of Event** _____

SECTION IV AGREEMENT and CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE	WAIVER OF COVERAGE
_____ / ____ / ____ Employee Signature Date	<input type="checkbox"/> I waive dental coverage for my dependents and/or myself. (Please indicate reason below) <input type="checkbox"/> I (We) have coverage under another dental plan. <input type="checkbox"/> I (We) do not wish to enroll _____/____/____ Employee Signature Date

AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am making application for the coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa. I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental of Iowa on my behalf. This authorization is to remain in effect until I or my employer or Plan Sponsor notifies Delta Dental of Iowa to the contrary. I understand coverage for the dental policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental of Iowa. I further understand that Delta Dental of Iowa establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental of Iowa will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental of Iowa will be entitled to declare the dental policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental of Iowa when reasonably related to the dental coverage for which I have applied. If any law or regulation requires additional authorization for release of dental records, I will give this authorization.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental benefits, which may require additional limitations and waiting periods. . I also understand Delta Dental of Iowa, reserves the right to reject such an application.

NONDISCRIMINATION AND ACCESSIBILITY

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.

Required Federal Notice-Nondiscrimination and Accessibility

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

Delta Dental of Iowa provides free language services to people whose primary language is not English. In addition, Delta Dental provides free services for people with disabilities such as auxiliary aids, written communication in other formats such as large print, audio or other formats. If you need these services, call 1-877-983-3582, hearing impaired (TY) call 1-888-287-7312.

Language Access Service

This Notice has Important Information. This notice has important information about your application or coverage through Delta Dental of Iowa. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-877-983-3582.

Arabic –

يحتوي هذا الإشعار معلومات هامة. يحوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Delta Dental of Iowa. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 1-877-983-3582.

Chinese – 本通知有重要的訊息。 本通知有關於您透過 Delta Dental of Iowa 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 字 1-877-983-3582。

French – Cet avis contient des informations importantes. Cet avis contient des informations importantes concernant votre demande ou la couverture offerte par Delta Dental of Iowa. Prenez note des dates butoirs indiquées dans le présent avis. Vous devrez peut-être effectuer certaines démarches dans les délais prévus pour conserver votre couverture santé ou l'aide financière à laquelle vous pouvez prétendre. Vous avez le droit d'obtenir ces informations et de recevoir de l'aide dans votre langue gratuitement. Appelez le 1-877-983-3582.

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Delta Dental of Iowa. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-877-983-3582.

Hindi – इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या Delta Dental of Iowa के माध्यम से बीमे के बारे में महत्वपूर्ण जानकारी शामिल है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या लागतों में मदद के लिए आपको कुछ निश्चित समय-सीमाओं तक कार्रवाई करने की ज़रूरत हो सकती है। आपको कोई कीमत दिए बिना यह जानकारी और सहायता अपनी भाषा में प्राप्त करने का अधिकार है। 1-877-983-3582 पर कॉल करें।

Karen – တာကွဲးနိဉ်အဝဲအံးနိဉ်အိဉ်ဒီးတာဂုတ်တာကျိလောအရူဒိဉ်
တဖဉ်နိဉ်လိာ်. တာကွဲးနိဉ်အဝဲအံးအိဉ်ဒီးတာဂုတ်တာကျိလော
အရူဒိဉ်ဘဉ်ယးဒီးနလံဝဲတံထီဉ် မ့တဖုာ် တာကျိကောဒါဉ်ဖျိ Delta Dental of Iowa နနိဉ်လိာ်. ယုကွာ်မုာ်နံးမုာ်သိအိဉ်သ့ဉ်လောတာကွဲးနိဉ်အံးတကွာ်. ဘဉ်သ့ဉ်သ့ဉ်နကဘဉ်ပံးနုာ်မုာ်ဒါလောမုာ်နံးမုာ်သိလောတာဆာတ်ဝဲလံာ်လောနကလံာ်နတံာ်အိဉ်အုဉ်အိဉ်ဘုတ်ကျိကော မ့တဖုာ် တာမာ်လောနကဘဉ်ဟ့ဉ်အပူာ်နနိဉ်လိာ်. နနိဉ်ဒီးတာဂုတ်တာလောနကဒီးနုာ်ဘဉ်တာမာ်လောဒီးတာဂုတ်တာကျိလောနကျိဉ်ဒုဉ်နဲလောတလံာ်ဟ့ဉ်အပူာ်ဘဉ်နနိဉ်လိာ်. ကိး 1-877-983-3582 တကွာ်.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Delta Dental of Iowa를 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움을 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 1-877-983-3582로 전화하십시오.

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັກ ຫຼື ການຄຸ້ມຄອງ ໆທ່ານໂດຍຜ່ານ Delta Dental of Iowa. ເບິ່ງກຳນົດການໃນແຈ້ງການສະບັບນີ້, ເບິ່ງກຳນົດການໃນແຈ້ງການສະບັບນີ້ ຍກຳນົດເວລາທີ່ແມ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງສະເພາະຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແຈ້ງການຊ່ວຍເຫຼືອ ອົງ ນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-877-983-3582.

Pennsylvania Dutch – Die Bekanntmachung gebt wıchdichi Auskunft.

Die Bekanntmachung gebt wıchdichi Auskunft baut dei Application oder Coverage mit Delta Dental of Iowa. Geb Acht fer wıchdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimme Deadlines, so ass du dei Health Coverage bhalde kansch, oder bezaahle helfe kansch. Du hoscht es Rech fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschet nix. Ruf yuscht selli Nummer uff: 1-877-983-3582.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Delta Dental of Iowa. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры до определенного срока для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-877-983-3582.

Bosnian/Croatian – U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko Delta Dental of Iowa. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određene radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imaete pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-877-983-3582.

Spanish – Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Delta Dental of Iowa. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-877-983-3582.

Tagalog – Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Delta Dental of Iowa. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaaring mangailangan ka na magsagawa ng habkang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-877-983-3582.

Thai – ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอขอบเขตประกันสุขภาพของคุณผ่าน Delta Dental of Iowa ดูกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-877-983-3582.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Delta Dental of Iowa. Xin xem ngay then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-877-983-3582.