Please send completed application to:
Consumer Direct Team
P.O. Box 3384
Lisle, IL 60532

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: ☐ Delta Dental Individual Kids Preferred Plan ☐ Delta Dental PPO Gold Plan ☐ Delta Dental PPO Gold with Individual Kids Preferred Plan
☐ Delta Dental PPO Silver Plan ☐ Delta Dental PPO Silver with Individual Kids Preferred Plan ☐ Delta Dental PPO Bronze Plan

Monthly Rate:	Individual Kids Preferred Plan	Select Type of Coverage:	Monthly Rates:	Gold	Gold with Individual Kids Preferred Plan	Silver	Silver with Individual Kids Preferred Plan	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: ______________________________

Authorization and Signature

By signing below, I hereby authorize Delta Dental of Illinois (DDIL) to deduct the premium amount stated above from the listed bank account or credit card on or about the 27th of each month for my monthly premium payment (if the payment method selected is monthly). I understand that the initial ACH debit or credit card charge to my account will occur immediately and if I have selected an annual payment option, the initial ACH debit or credit card charge will reflect the annual premium.

I agree that this authorization will remain in full force and effect until DDIL has received written notification from me that I am terminating it. I agree to notify DDIL in writing of any changes to my account information or termination of this authorization at least three (3) days (for ACH debits) or twenty-five (25) days (for credit card charges) prior to the next billing date.

I understand that DDIL will notify me in advance of any changes to the premium amount. By signing below, I hereby authorize DDIL and the bank or credit card company identified above to process the ACH debits or credit card charges authorized here.

If I am not the insured person under this policy, I confirm that I am agreeing to pay this insurance premium on behalf of the insured person. Unless the insured person is a minor for whom I am a parent or legal guardian, I understand that any changes to the policy that may affect the charge amount will be communicated to the insured person only.

I agree that if I have any problems or questions regarding this authorization or my insurance policy, I will contact DDIL for assistance at 877-824-2776. I also agree that I will not dispute any charges with my bank or credit card company without first making good faith effort to resolve the dispute directly with DDIL. I guarantee that I am the account holder for this bank account (for ACH debits) or legal card holder (for credit card charges) and that I am legally authorized to enter into this Recurring ACH Debit/Credit Card Billing Authorization Agreement with DDIL.

Additional Information if paying by ACH debit:

If my financial institution rejects an ACH debit from DDIL due to insufficient funds, I understand and agree that DDIL may in its discretion attempt to process the charge again within thirty (30) days. I understand that if my bank dishonors any ACH debit requested by DDIL under this agreement, DDIL may assess me a $25 service charge, and DDIL may collect that service charge by means of an ACH debit. I also understand that DDIL may apply that service charge each time it resubmits an ACH debit request that is rejected (even if it is for the same unpaid amount as a previously-rejected ACH debit request).

Additional Information if paying with credit card:

I understand that any transaction that is dishonored by my credit card company intended for payment to DDIL may be assessed a $25 service charge by DDIL. Further, I authorize DDIL to make any charges on a future policy I may purchase from DDIL on the same credit card if I give verbal consent to DDIL.

Signed: ______________________________ Date: ______________________________

In making this application to Delta Dental of Illinois, 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 understand that, if applicable, my electronic signature on this form operates as my original signature. 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	***Note to brokers:***
Broker ID: ______________	*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.*
Broker/Agency Name: ______________	
Broker Email: ______________	