



INDIVIDUAL ENROLLMENT/CHANGE APPLICATION

This application form must be received by Delta Dental of Iowa 10 days prior to the effective date.
The effective date is always 1st of the month.

| | | |
|---|-------------------------------------|---|
| Product Choice: <input type="checkbox"/> Preventive <input type="checkbox"/> Preferred Choice | Social Security No. _____ | Effective Date ____ / 01 / ____ |
| <input type="checkbox"/> New Applicant <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name/Address Change | | |

| | | | | |
|------------------|---|---|--|--|
| SECTION I | Name (First, Middle Initial, Last) _____ | Telephone () _____ | Date of Birth ____ / ____ / ____ | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| | Complete Address – Street _____ City _____ State _____ Zip _____ | Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other (specify) _____ | E-mail address: _____ | |
| | | Please check the coverage you are applying for: <input type="checkbox"/> Single <input type="checkbox"/> Two-person <input type="checkbox"/> Family | | |

SECTION II ELIGIBLE DEPENDENTS

| List eligible members of your family to be covered | Social Security Number | Birthdate | Sex | Full-Time College Student | Disabled Status | Other Dental Coverage |
|---|------------------------|----------------|--|--|---|---|
| First Name Middle Initial Last (if different) | | | | | | |
| Spouse | _____ | ____/____/____ | <input type="checkbox"/> M <input type="checkbox"/> F | | Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dependent | _____ | ____/____/____ | <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"/> No <input type="checkbox"/> Yes |
| Dependent | _____ | ____/____/____ | <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"/> No <input type="checkbox"/> Yes |
| Dependent | _____ | ____/____/____ | <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"/> No <input type="checkbox"/> Yes |

Other Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, 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 Dependents 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 of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE

_____ / ____ / ____
 Applicant Signature Date

_____ / _____
 Agent Name Agency * NPN Insurance License #

| |
|---------------------------------------|
| Internal Use Only Agency ID# _____ |
|---------------------------------------|

*This is the agency authorized by Delta Dental of Iowa to sell individual dental products.

