DELTA DENTAL

Northeast Delta Dental

Application for Dental Coverage

Please send completed application to:
Delta Dental
P.O. Box 103
Stevens Point, WI 54481

PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL
Customer Service: 888-899-3736
www.deltadentalcoversme.com

Section 1 | Policyholder Information

Policyholder Last Name	First Name	Middle Initial	Sex: Male/Female

Home Address (Mailing)	City	State	ZIP	Phone No. (with area code)

Email Address*	Date of Birth (MM/DD/YYYY)	Marital Status:

**By providing my email address, I agree to receive communications regarding my Policy and benefits electronically. This authorization may be revoked on the website [www.deltadentalcoversme.com] or in writing to the address listed above.*

Plan Selection

☐ Basic Plan ☐ Preferred Plan ☐ Premium Plan ☐ Premium Plus Plan ☐ Traditional Plan

To learn more about plan designs visit www.deltadentalcoversme.com or call 888-899-3736.

Employment Status: ☐ Employed ☐ Self-employed ☐ Retired ☐ Not currently working

Reason for Application: ☐ New Enrollment ☐ Change of Dependent(s)

Section 2 | Persons to be covered

First Name	Last Name	Date of Birth (MM/DD/YYYY)	Relationship to Policyholder	Sex M/F	Disabled Dependent Y/N
			SELF		

PRIOR DENTAL INSURANCE COVERAGE. Were you (the policyholder) covered by a dental plan in the past 63 days?
☐ Yes ☐ No

Name of Previous Carrier	Policy Start Date	Policy End Date

Policies issued in the State of New Hampshire are underwritten by:
Delta Dental Plan of New Hampshire Concord, NH 03302.
All policies administered in part by Encara Corporation Delta Dental of Wisconsin

Form No. 11.10.3.16

Section 3 | Payment Instructions

To calculate rates please visit www.deltadentalcoversme.com or call 888-899-3736.

A debit, credit card or EFT (Electronic Funds Transfer) may be used to pay monthly, semi-annually or annually. If paying by check, remittance for the full annual 12 month premium is required, payable to Delta Dental.

Choose payment method: ☐ Debit/Credit Card ☐ Annual Check ☐ EFT

Please complete the following information for payment by Debit/Credit Card:

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name:_____

Cardholder Address (if different than Policyholder):_____

City:_____ State: _____ ZIP Code:_____

Card Number:_____

Expiration Date: Month _____ Year _____ Security Code (from back of card): _____

Payment Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

Please complete the following information for payment by EFT:

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:_____

Please attach a voided check to this application if you will be using your checking account for automatic payments.

I authorize Delta Dental to initiate debit entries from my above bank account or Debit/Credit card for my dental premiums.

Signature: X_____ Date: X_____

Your payment for the upcoming period will be deducted from your account on the 27th of the previous month. If the charge is declined for any reason, we will attempt to charge you again on the 27th of the following month. If the charge is still declined, we will immediately terminate your contract for nonpayment of premium, effective as of the last day of the grace period.

In submitting this application to Delta Dental for dental coverage, 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 Delta Dental. I understand that this is a contract under which I am obligated to pay premium for the term of the contract. I further agree that the coverage requested is subject to the approval of Delta Dental and that no representative has authority to make changes or modify this application for coverage.

I represent that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Policy to be null and void. In the event it is discovered that I have provided false or misleading information in connection with this application for the purpose of defrauding Delta Dental, Delta Dental shall inform the appropriate state and regulatory authorities, including, but not limited to, my state's insurance commissioner. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

By my submission of this application I represent that I do not have other active dental coverage. If at any time I obtain other dental coverage, Delta Dental reserves the right to terminate this plan with thirty (30) days notice.

Statements herein are deemed to be representations not warranties.

The Policy will become effective on the first day of the month following approval of this application.

X_____ X_____

Policyholder Signature Date

Coverage is contingent upon underwriting acceptance

Agency Use Only	Agency Name or Code:	Alternative Benefit Solutions	Agent Name:	Thomas Buonanduci	Agent #:	379354

Agent Signature: _____ *Date:* _____

Commission payment may not be supported for all products. Please contact Delta Dental for more information.

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Northeast Delta Dental

Discrimination is Against the Law

Northeast Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Northeast Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Northeast Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

  If you need these services, contact Sheila Sarabia, Compliance Manager.

If you believe that Northeast Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sheila Sarabia, Compliance Manager
One Delta Drive
Concord, NH 03301
603-223-1127
TTY: 1-800-332-5905
Fax: 603-223-1035
ssarabia@nedelta.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Sheila Sarabia, Compliance Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

DELTA DENTAL

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Language Assistance Services

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-5700 (ATS : 1-800-332-5905).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-832-5700 (TTY: 1-800-332-5905).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-832-5700 (TTY: 1-800-332-5905)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-832-5700 (TTY: 1-800-332-5905).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-832-0075 (رقم هاتف الصم والبكم: 1-800-233-5095).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-832-5700 (телетайп: 1-800-332-5905).

ध्यान दनु होस:्तपाइ ले नेपाल बोल्नहन्छ भन तपाइ को निम्त भाषा सहायता सवाहरू नःशल्क रूपमा उपलब्ध छ । फोन गनु होसर् ्1-800-332-5700 (ट टवाइ : 1-800-332-5905) ।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-832-5700 (TTY: 1-800-332-5905).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-832-5700 (TTY: 1-800-332-5905) まで、お電話にてご連絡ください。

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-832-5700 (TTY: 1-800-332-5905).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-832-5700 (TTY: 1-800-332-5905) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-832-5700 (TTY: 1-800-332-5905).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-832-5700 (TTY: 1-800-332-5905).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-832-5700 (TTY: Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-332-5905).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-832-5700 (TTY: 1-800-332-5905).