DELTA DENTAL

Please send completed application to:
Eligibility Department
P.O. Box 3384
Lisle, IL 60532
Fax (630) 369-0384
eligibility@deltadentalil.com

Application for Individual Dental Insurance

PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL

Eligibility Department: 800-752-7971

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

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:
☐ Newspaper Ad ☐ Dentist Office ☐ Internet ☐ Other Media Ad ☐ Friend/Relative ☐ Other

Select Plan:	Select Type of Coverage:	Monthly Rates:	Gold Plan	Silver Plan	Bronze Plan
☐ Gold	☐ Single	Single	$_____	$_____	$_____
☐ Silver	☐ Two-Person	Two-Person	$_____	$_____	$_____
☐ Bronze	☐ Family (Three or more persons)	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

A check must be submitted for the first payment on your policy if you choose bank account as your method of payment. Thereafter, all premiums must be paid electronically using your checking/savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on the 1st of the month.

Please complete the following information if you choose to have deductions automatically taken monthly, for premium payments from an account you designate:

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 or deposit slip from your designated account if you choose to have deductions for verification.]

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: _____]

I hereby authorize Delta Dental of Illinois to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Signed: _____Date: _____

I understand that any transaction that is dishonored by my bank/credit card intended for payment to Delta Dental, may be assessed a $25.00 service charge by Delta Dental of Illinois.

In making this application to Delta Dental of Illinois (DDIL), 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 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 not eligible for dental coverage through Delta Dental of Illinois through my current employer. If at any time I become eligible for Delta Dental of Illinois group coverage through my employer, Delta Dental reserves the right to terminate this plan with thirty (30) days notice.

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

Coverage is contingent upon underwriting acceptance

FOR AGENT USE ONLY	***Note to agents:***
Agency Code: # 1494	*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.*
Agent Name: Ryan Kennelly	
General Agency: Euclid Managers	