ELECTRONIC FUNDS TRANSFER (EFT)

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize Delta Dental of Arizona to initiate debit entries the first week of the month and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account and the financial institution indicated below:

_____

Name of Financial Institution City, State, ZIP

_____

Transit/Routing Number Account Holder's Name Account Number

Type of Account (Select one): [ ] Checking [ ] Savings

_____

Account Holder's Signature

Please Enter Client Payment Information At www.deltadentalaz.com

Your premium payment check must be from the same account as your monthly EFT withdrawals

This authority is to remain in full force and effect until Delta Dental has received written notification from me of its termination in such time and in such manner to afford Delta Dental of Arizona and my financial institution a reasonable opportunity to act upon it.

I understand that any EFT transactions that are dishonored by my financial institution intended for payment to Delta Dental of Arizona may be assessed a $25 service charge.

_____

Please Print Applicant Name *(If different from banking information above)* Phone Number

_____

Applicant Social Security Number Date

Please review this check-list to ensure you have completed all 3 steps for enrollment:

Step 1 – I have completed online enrollment for my client ❒ (check if done)

Step 2 – I have completed my client's payment information online ❒ (check if done)

Step 3 – Keep enrollment forms for your records only, do not mail them in ❒ (check if done)

If your client is paying by check, please mail their 3 month premium payment along with their completed online enrollment (Not this form) to:

Delta Dental of Arizona
Individual Plan Enrollment
P.O. BOX 63694
Phoenix, AZ 85082

INDIVIDUAL PLAN - ENROLLMENT FORM

BROKER COPY ONLY – DO NOT MAIL – ONLINE ENROLLMENTS ONLY

Please note: Following your initial 3 months premium payment, monthly premiums must be paid by monthly Electronic Funds Transfer (EFT)

If your client is paying by check, please mail their 3 month premium payment along with their completed online enrollment (Not this form) to:

Delta Dental of Arizona
Individual Plan Enrollment
P.O. BOX 63694
Phoenix, AZ 85082-1595

FOR DELTA DENTAL USE ONLY
Group #: _____
Eff. Date: _____ Wait Start Date:_____
Rate Code: _____

APPLICANT INFORMATION			
Social Security Number ☐☐☐☐☐☐☐☐☐		**Marital Status** ❑ Single ❑ Married **Gender** ❑ M ❑ F **Date of Birth** _____/_____/_____	
Applicant's Last Name	First	Middle Initial	Home Telephone
Home Address (Mailing)	City	State	Zip Code
Email Address			

DEPENDENT INFORMATION* See below for definition of eligible dependents

Last Name (if different) First, M.I.	Social Security Number	Relationship to Applicant	Gender (M/F)	Date of Birth	Full-time Student	
					Yes	No

Eligible Dependents:* Your lawful spouse, unmarried children under age 19 or 23 if full-time student, or those of your lawful spouse, including newborn children, stepchildren, disabled children, persons under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption with you in accordance with applicable state or federal law. Verification of dependent status for children over age 19 may be required. **If you need additional space to list dependents, please list them on a separate piece of paper, including all of the above information.

SECTION D: PLAN SELECTION / PRIOR COVERAGE CONFIRMATION

Choose Your Plan See Summary of Benefits for Plan descriptions

Coverage *(Choose only one)*		**Individual** *Single coverage only covers you*		**Individual & Family** *Family coverage includes you and multiple qualified dependents*
Plan Green Choose Coverage - Mark selection with an "X"		Individual $44.32		Individual & Family $100.04
Plan Blue Choose Coverage - Mark selection with an "X"		Individual $41.72		Individual & Family $94.97
Plan Purple Choose Coverage - Mark selection with an "X"		Individual $30.53		Individual & Family $71.38
Plan Orange Choose Coverage - Mark selection with an "X"		Individual $25.20		Individual & Family $58.27
Plan Yellow Choose Coverage - Mark selection with an "X"		Individual $16.27		Individual & Family $41.15

PRIOR COVERAGE CONFIRMATION

Have any of the enrollees been previously covered by a Delta Dental plan? ❑ Yes ❑ No

- What state provided your prior dental insurance coverage? _____
- Name of employer where your Delta Dental benefits were obtained: _____
- Employer Group number: _____
- Effective dates of Delta Dental insurance: _____ Start _____ End
- Reason for termination of coverage: _____

PRIOR COVERAGE CONFIRMATION - continued

Which dependents had prior coverage? (Dependent Name)	Effective Date of Delta Dental Insurance Start Coverage Date – End Coverage Date	Reason for Termination
	_____/____/_____ - _____/____/_____	
	_____/____/_____ - _____/____/_____	
	_____/____/_____ - _____/____/_____	
	_____/____/_____ - _____/____/_____	

PRIOR COVERAGE CONFIRMATION - Continued

❑ **I agree**
❑ **I do not agree**

I understand that upon request I will be able to provide proof of prior Delta Dental coverage and/or will assist DDAZ to obtain information necessary for validation of prior eligibility. If I am unable to provide or will not assist DDAZ obtain proof of prior Delta Dental coverage all benefit waiting periods will apply. I authorize DDAZ to contact my previous Delta Dental carrier to verify my previous dental insurance coverage.

CONFIRMATION & PLAN ELIGIBILITY

❑ **I agree**
❑ **I do not agree**

I attest that I am not eligible for Delta Dental of Arizona group coverage through my current employer. I understand that if at any time I become eligible for Delta Dental of Arizona group coverage through my employer, DDAZ reserves the right to terminate this plan with thirty (30) days notice.

❑ **I agree**
❑ **I do not agree**

I understand that enrollments are for consecutive 12-month period(s) and my monthly premium payment is subject to change on the anniversary date. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period.

AUTHORIZATION

❑ **I agree**
❑ **I do not agree**

I hereby apply for membership with Delta Dental of Arizona pursuant to the terms specified on the **Terms and Conditions** pages of this form, which are hereby incorporated by reference. By selecting, "**I agree**", I declare I am a resident in the State of Arizona, that I am not eligible for Delta Dental of Arizona group coverage through my current employer, and that I or my spouse do not work in the dental profession.

Applicant's Signature / Authorization	**Social Security Number**	**Date Signed**

Upon acceptance member will receive a welcome letter with their member ID. The member ID is used to set up the subscriber connection online to print an ID card, review benefit booklets and claims. ID cards will only be available through the subscriber connection online.

Terms and Conditions

I hereby apply for membership with Delta Dental of Arizona, Inc. (Delta Dental) and I understand and agree that my coverage, and that of any dependents, will become effective on the date established by my dental coverage policy (referred to as "Plan"). I agree to be bound by the provisions of the Plan. Any dependents that are later added to my Plan will have different effective dates.

I understand that enrollments are for consecutive 12-month period(s) and my monthly premium payment is subject to change on the anniversary date. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period. Should I decide to cancel my plan; all individuals previously covered under my plan will not be allowed to re-enroll within the subsequent 24 months.

I attest that I am not eligible for Delta Dental of Arizona group coverage through my current employer. I understand that if at any time I become eligible for Delta Dental of Arizona group coverage through my employer, DDAZ reserves the right to terminate this plan with thirty (30) days notice.

I am responsible to notify Delta Dental upon any change that would make me or any dependent ineligible for coverage.

If any services covered under this Contract are also provided under any other dental benefits contract, DDAZ will pay no more than the total cost of such dental services than is required by the Subscriber's DDAZ dental benefits summary. This practice is consistent with state and/or federal law and industry standards (including the National Association of Insurance Commissioners Employer Group Coordination of Benefits Model Regulation). Upon request, the Individual will assist DDAZ in obtaining information necessary to coordinate and avoid duplication of benefits.

I hereby authorize any physician, dentist, hospital, or insurer having records of information concerning health history or other insurance for me and those persons specified as dependents to furnish such records, data, or information as may be requested by Delta Dental or their duly authorized representative to review eligibility, determine benefits (if any), contract administration, detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. I hereby authorize Delta Dental to release information related to my benefits and those persons specified as dependents benefits under this plan to any dental office. I understand that this authorization is valid for a minimum of 12 consecutive months from the date signed and/or the latest renewal during the open enrollment period. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I or any authorized representative may receive, upon request, a copy of this authorization. This information may also be given by Delta Dental to its legal representatives.

To the extent allowed by law, Delta Dental is authorized to furnish all information and copies of records requested by other insurers, dental plans or other parties for the purposes of determining eligibility for coverage or benefits, coordinating benefits, utilization review or audit.

Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this application, the identification card and the dental coverage policy will constitute the contract.

Uses and Disclosures of Health Information

At Delta Dental, we use health information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the dental coverage policy and to perform assurance. We NEVER sell any information we collect while processing transactions on your request. You can be assured that when processing or servicing a transaction at your request, only the minimum necessary information regarding your account or personal history information will be used or disclosed, as permitted by law. Delta does not routinely record the identity of the recipient of the information that we have disclosed to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the dental coverage policy and to perform quality assurance. For more information about our privacy practices, please visit www.deltadentalaz.com under privacy policy or contact Customer Service, Phone: (602) 588-3624 or (888) 335-8214, Email: customerservice@deltadentalaz.com.