DELTA DENTAL

Individual Dental Application/Update

Apply online now at **www.mysmilecoverage.com** or complete this form and mail to:

Delta Dental of North Carolina
32399 Collection Center Drive
Chicago, IL 60693-0323

- ❑ New Application — Check for first-time application for yourself or your Spouse.
- ❑ Change/Correction to Information—Check if any changes are being submitted on this form.
- ❑ Termination of Benefits—Check only if you are terminating coverage for yourself or your Legal Spouse.

Previous Coverage
Will this policy replace or change any existing policy of dental insurance? ☐ Yes ☐ No

If you are purchasing this coverage to replace an existing Delta Dental of North Carolina plan, please provide the anticipated termination date of your current plan: _____. If this coverage will replace a plan with another carrier, please submit a copy of the Certificate of Creditable Coverage and a list of covered benefits. A Certificate of Creditable Coverage and covered benefits can be obtained from your previous insurance carrier or your employer group administrator.

(This section must be completed for us to process your application or update your records. Please print clearly or type.)

Example ABCDEF123456

Applicant Name *(First)* *(M.I.)* *(Last)*

Birth Date Sex Applicant Social Security Number
Male ☐ Female ☐ – –

Street Address ❑ Check here if this is a new address

City State ZIP Code –

E-mail Address *(Optional)* Telephone Number – –

Coverage Effective Date
– – (Access Code: Internal Use Only)
(date coverage takes effect for you and/or your Spouse)

Legal Spouse Information (*Please complete this section if you are enrolling your Spouse for the first time or if you have checked Change/Correction above and are changing information about your Spouse that was previously submitted. You must include your Spouse's first and last names.)*

Legal Spouse Name *(First)* *(M.I.)* *(Last)*

Birth Date Sex Social Security Number
Male ☐ Female ☐ – –

Dependent Child Information

#1- Dependent Child Name *(First)* *(M.I.)* *(Last)*

Birth Date Sex Social Security Number
Male ☐ Female ☐ – –

#2- Dependent Child Name *(First)* *(M.I.)* *(Last)*

Birth Date Sex Social Security Number

Male ☐ Female ☐ ___ – ___ – ____

#3- Dependent Child Name *(First)* *(M.I.)* *(Last)*

Birth Date Sex Social Security Number

Male ☐ Female ☐ ___ – ___ – ____

#4- Dependent Child Name *(First)* *(M.I.)* *(Last)*

Birth Date Sex Social Security Number

Male ☐ Female ☐ ___ – ___ – ____

#5- Dependent Child Name *(First)* *(M.I.)* *(Last)*

Birth Date Sex Social Security Number

Male ☐ Female ☐ ___ – ___ – ____

Payment Information (The amount payable for coverage varies based on the coverage option selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling):

❑ Plan A Enhanced
❑ Plan B
❑ Plan C

Payment Frequency:

❑ Annual (If you are paying by check, you **must** choose this option and pay the amount due in full)
❑ Monthly (If you are paying by credit card or automatic withdrawal, you may choose this option)

Choose the payment method:

❑ Check payable to Delta Dental **(you may pay by check only if you choose an annual payment)**
❑ MasterCard ❑ VISA ❑ American Express ❑ Discover

Card Number Exp. Date

____ ____ ____ ____ __ – ____

Cardholder Name *(as it appears on card)*

Credit Card Billing Address *(if different from mailing address)*

Street Address

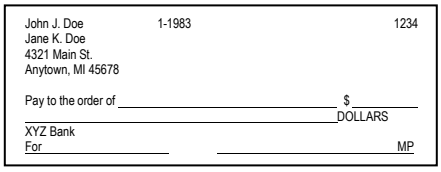
City State ZIP Code

__ – ____

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for premiums due. This authorization will remain in effect until Delta Dental has received written notice from me of its termination. If the billing amount changes, Delta Dental will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature _____ Date _____

❑ Automatic withdrawal from bank account



Bank Name

Routing Number Account Number

❑ Checking Account

❑ Savings Account

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature _____ Date _____

Validation Question (choose ONE and answer below):

❑ Mother's maiden name (last name only) OR ❑ City in which you were born OR ❑ Name of first pet

Certification

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (Please see the following page for state-specific variations of this fraud notice.)

Applicant's Signature _____ Date _____

Please mail enrollment form (and check, if applicable) to:

Agent Certification (if applicable): I hereby certify that I have truly and accurately recorded on this application, the information supplied by the Applicant. I further certify that I have been duly appointed by Delta Dental to solicit and negotiate and sell individual dental plans on its behalf.

Agent's Name (PRINTED) _____

Agent's Signature _____ Date _____

Agent's Phone Number _____

Agent's Access Code/Writing Number (required) _____

If you have any questions about filling out this form, please contact our Customer Service Department at (800) 971-4108.

Please mail application form (and check, if applicable) to:

Delta Dental of North Carolina
32399 Collection Center Drive
Chicago, IL 60693-0323