Delta Dental Individual and Family Enrollment Form

Delta Dental of Nebraska
Dental Enrollment Department
PO Box 330
Minneapolis MN 55440-0330

Please complete in blue or black ink only. For information or assistance in completing this form, call Customer Service at 1-888-223-2954.

Applicant Information – To be eligible to enroll, an applicant cannot currently be covered by another Delta Dental of Nebraska group or individual dental plan. Children under age 19 may apply for Pediatric Dental Plan; however, a parent/guardian must sign the application and is responsible for payments.

Last Name	First Name	Middle Initial	Social Security Number

Gender ☐ M ☐ F	Day Phone Number	E-mail Address	Date of Birth / /

Address	City	State	ZIP Code

Agent Name	Agent ID	Agent Tax ID	Agent License ID	Agent Paid ID
Chad Larson		508197115		

Select Plan: Select one Adult Dental Plan for adult(s) and/or dependent child(ren) age 19+ being enrolled. Select a Pediatric Dental Plan for dependent child(ren) under age 19 being enrolling.

Adult Dental ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan G

Pediatric Dental ☐ Plan A ☐ Plan B

Select Who Is To Be Enrolled: ☐ Applicant Only ☐ Applicant and Dependent (s)

Complete this section if anyone other than the applicant listed above is being enrolled. Dependent children under age 26 can be enrolled.

Relationship to Applicant	First Name, Middle Initial, Last Name	Gender		Date of Birth (mm/dd/yyyy)
☐Spouse ☐Domestic Partner		M	F	
Dependent Child		M	F	
Dependent Child		M	F	
Dependent Child		M	F	

Select One Payment Option and Billing Frequency The first premium is charged immediately. Future premiums are deducted/charged around the 20th business day of each payment period.

☐ **A. Direct Withdrawal from Checking/Savings Account:** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual**
Name on Checking Account ______________________________
Bank Name ______________________________
Routing Number ____________________ Checking Account Number ____________________

☐ **B. Credit Card or Debit Card**: ☐ **Monthly** ☐ **Quarterly** ☐ **Annual** ☐ MasterCard ® ☐ Visa ®
Credit/Debit Card Number ______________________________ Exp. Date _____/_____ Security Code ______
Name As It Appears On Credit/Debit Card ______________________________

☐ **C. Check:** ☐ **Quarterly** ☐ **Annual** Send this form and a check payable to Delta Dental of Nebraska.

Authorization and Verification – Sign and date application as verification of your enrollment.

I have read, or have had read to me, the completed application and I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy. I authorize Delta Dental to withdraw funds from my bank account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made on time I will no longer be eligible for coverage. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of [12- 24] months.

Applicant/Parent Signature: **Date:**

3 Easy Ways to Submit your Application for Enrollment:

#1 Email:
enrollddne@deltadentalneadmin.org

#2 Fax:
800-821-5946

#3 Mail:
Delta Dental of Nebraska
Attn: Enrollment Department
PO Box 330
Minneapolis, MN 55440-0330