Application for Delta Dental
2020 Individual & Family Dental Plans

6705 Faith Drive * Cheyenne, WY 82009
307-632-3313 * 800-735-3379 * FAX 307-632-7309
www.deltadentalwy.org

Subscriber Information

*Must be 18 years of age and a Wyoming Resident to apply

First Name: (Subscriber)	Last Name:		
Social Security Number:	Date of Birth:	Gender: ☐ F ☐ M	
Home Address:	City:	State:	ZIP:
Phone Number:	Email Address:		

Notice: All correspondence regarding this plan will be conducted electronically unless you request to be contacted by mail. Correspondence will be sent to the email address listed on this application. You must maintain a valid email address to ensure delivery and receipt of information regarding your plan. We will not send private health information in an email.

☐ **Check here if you prefer to receive correspondence by mail.**

Eligible Dependent(s) to Be Covered Under This Policy

First Name:	Last Name: (if different from Subscriber)	Date of Birth:	Gender:
Spouse:			
Dependents:			

Dependent children are covered through the end of the month in which they turn 26.

☐ **Check here if you have been continuously enrolled under a dental plan for at least the last three months. If you have been covered, please send proof of coverage in with your application.**

Plan Selection: ☐ **Preferred** ☐ **Basic**

Coverage Selection: ☐ **Individual** ☐ **Individual plus One** ☐ **Individual plus Family**

FOR AGENT USE ONLY
Agent Name: _____ Agent Signature: _____
Phone: _____ Date: _____

Payment Options

Payment Method 1

☐ **Annual Premium Payable by Check**

Make check payable to Delta Dental of Wyoming with this application. Applications must be received by the last working day of the month for coverage to begin the next month.

Name; _____ Signature: _____ Date: _____

Payment Method 2 ☐ **Checking Acct**

☐ **Automatic Monthly Withdrawal from Bank Account (EFT)** ☐ **Savings Acct**

ACH payments occur on the 5th of each month (or next business day). You must complete the information below, attach a voided check and sign the authorization agreement.

I authorize Delta Dental of Wyoming to conduct an electronic funds transfer of my designated personal bank account until further notice for payment of my premiums. I am an authorized check signer on the account listed below and I authorize all of the above as witnessed by my signature below.

Financial Institution: _____ City: _____

State: _____ Zip: _____ Routing Number: _____ Account Number: _____

This authorization is to remain in effect until DELTA DENTAL OF WYOMING has received written notification from me of its termination. I must provide Delta Dental of Wyoming with 30 days written notice of plan termination.

Name: _____ Signature: _____ Date: _____

Coverage Period

The initial term of your policy will be for one year from the effective date. The effective date of your plan will be the first of the month following receipt of your completed application and payment or payment authorization. After the initial term, this policy will renew automatically establishing a new effective date each year until a change is submitted or until this agreement is terminated. This policy may be terminated upon thirty (30) days written notice to Delta Dental of Wyoming. Additionally, I understand that if I terminate or discontinue enrollment, I will not be able to re-enroll for a period of 36 months.

Delta Dental of Wyoming reserves the right to change premium rates upon renewal of the policy. Notice of rate changes and/or plan modifications will be provided at least 45 days before the effective date. Delta Dental agrees to keep your coverage in force as long as you continue to pay the premiums on time and as long as you retain residency in the state of Wyoming.

Terms

By signing below, you verify that you have read and agree to the following:

I understand that there is a Six-month waiting period on Basic Services and a Twelve-month waiting period on Major Services. (May be waived if you can provide proof of prior coverage, however you cannot have more than a 30-day break in credible coverage). I certify the information contained in this application is true and complete to the best of my knowledge. I understand that misrepresentation of submitted data may cause this application and subsequent policy to be null and void. I further understand that covered services are eligible for payment only if my Agreement is in effect at the time the services are provided. **If I want to terminate this policy, I must provide Delta Dental with 30 days' notice and I must provide this notice in writing**.

Subscriber Signature: _____ Date: _____