2021 - Delta Dental Individual & Family Plans
Enrollment Application
Off Marketplace – ACA Certified

Delta Dental of Wyoming
6705 Faith Drive
Cheyenne, WY 82009

Subscriber Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____

City: _____ Zip: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

Gender: ☐ Male ☐ Female Email Address: _____

Please check the plan and type of coverage you are applying for:

☐ Individual & Family High Plan + Pediatric

☐ Individual & Family Low Plan + Pediatric

Covered Dependents:

List all covered dependents you are enrolling. If additional space is required attach a list to this form & check here ☐

	First Name	Last Name	Date of Birth	Gender
Spouse:				☐ M ☐ F
Dependent:				☐ M ☐ F
Dependent:				☐ M ☐ F
Dependent:				☐ M ☐ F
Dependent:				☐ M ☐ F

Dependents are covered through the end of the year in which they turn 26

☐ Check here if you have been continuously covered under a dental plan for at least the last 3 months & provide proof of coverage.

The effective date of your plan will be the first of the month following receipt of your completed enrollment form and payment or payment authorization - enrollment forms must be received by the last working day of the month.

*** Coverage will terminate within 30 days if you or a covered family member moves out of state.**

Payment Method

Option 1: Check – Monthly or Annual Premium (Please include your first month's payment or annual payment with this form)

Option 2: Electronic Funds Transfer – Monthly premium (Please include a voided check with this form, funds will be drafted on or about the 20th of each month)

Option 3: Credit Card – Monthly premium (funds will be drafted on or about the 20th of each month)

Please carefully read the Agreement on the back of this form. A signature is required. **OVER** ⟶

Payment Method:

Choose your payment method:
- ☐ Check – Monthly Premium or Annual Premium
- ☐ Electronic Funds Transfer – Monthly premium
- ☐ Credit Card – Monthly Premium

Please complete the following information for payment by Electronic Funds Transfer:

Name of Financial Institution: _____

Financial Institution's City, State, Zip: _____

Type of Account (choose one) ☐ Checking ☐ Savings Name on Account: _____

Bank Routing Number: _____ Bank Account Number: _____

Please attach a voided check to this application if you will be using your checking account for automatic payments

Please complete the following information for payment by Credit Card:

☐ Visa ☐ MasterCard ☐ Discover Name on Card: _____

Card Number: _____

Expiration Date: _____month _____year Security Code: _____

I hereby authorize Delta Dental of Wyoming to initiate transactions from my above bank account or credit card for my dental insurance premiums.

Signed: _____ Date: _____

Please carefully read the Agreement below. A signature is required.

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. I understand that notice of rate changes and/or plan modifications will be provided by Delta Dental of Wyoming at least 45 days before the effective date. I understand that this policy may only be terminated upon thirty (30) days written notice to Delta Dental of Wyoming

(If paying by EFT or credit card) I authorize Delta Dental of Wyoming to conduct an electronic funds transfer (EFT) of my designated personal bank account or credit card until further notice for payment of my premiums. Monthly automatic withdrawals will continue until Delta Dental has received written notice from you that you want to cancel your coverage. This notice must be received in writing and by the 19th of the month for an effective date of the next month.

If I do not choose the EFT or credit card option, I will make either a monthly payment by personal check or an annual payment by personal check, in advance, for each coverage period. Regardless of the payment method, I understand that my enrollment is subject to Delta Dental approving my application and receiving my payment and if funds are not available or payment is not made on time, I (and my dependents) will no longer be eligible for coverage. I also understand that if I terminate or discontinue enrollment, I will not be able to re-enroll for a period of **36 months**.

Enrollee Signature: _____ Date: _____

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

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

FOR AGENT USE ONLY

Agent Name: _____

Agent Signature: _____

Phone: _____ Broker Certification Number: _____Date: _____