2025 Enrollment Application for Off Marketplace – ACA Certified 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

If applying for a Child Only plan – please enter the Child's information below

First Name:	Last Name:		
Social Security Number:	Date of Birth:	Gender: ☐ F ☐ M ☐ Other	
Mailing Address:	City:	State:	Zip:
Home Address (if different than Mailing Address)	City:	State:	Zip:
Phone Number:	Email Address:		

For child only plans please enter parent information below. Otherwise please skip this section.

Parent 1 - First Name:	Parent 1 - Last Name:	Date of Birth:
Parent 2 - First Name:	Parent 2 - Last Name:	Date of Birth:
Parent Phone Number:	Parent Email Address:	

Notice: All correspondence regarding this plan (other than your ID cards) 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

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

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

If additional space is required attach a list to this form & check here ☐

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

☐ Individual & Family High Plan + Pediatric ☐ Individual & Family Low Plan + Pediatric

The effective date of your plan will be January 1st or the first of the month following receipt of your completed enrollment form and payment or payment authorization (if you have a qualifying event). After the initial term, this policy will renew automatically on January 1st of each year, until a change is submitted or until this agreement is terminated. 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 Options

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)

Choose your payment method:

- ☐ Check – Monthly Premium or Annual Premium
- ☐ Electronic Funds Transfer – Monthly premium
- ☐ Credit Card – Monthly Premium

Monthly or 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.

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.

(If paying by EFT or with 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 **12 months**.

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 for those age 19 and up. If you have been continuously enrolled under a dental plan for at least the last three months your waiting periods may be waived. If you have been covered, please send proof of coverage with your application, which should include an outline of coverage (showing equivalent coverage) and information showing the start and end date of your policy. If you do not submit proof of prior coverage your waiting periods will NOT be waived.

If I want to terminate this policy, I must provide Delta Dental with 30 days' notice and I must provide this notice in writing.

Enrollee Signature: _____ Date: _____

Agent Information (If Applicable)

FOR AGENT USE ONLY

Agent Name: _____ Agency Name: _____

Agent Signature: _____

Appointed with Delta Dental of Wyoming?

☐ Yes ☐ No (if no, please contact Delta Dental of Wyoming for appointment paperwork)

Phone: _____ Date: _____

Consent

Consent to receive email messages containing notifications, tips, reminders, and links to surveys.

I agree to receive unencrypted email messages containing notifications, reminders, tips and links to surveys and information related to my dental insurance for treatment, payment and healthcare operations purposes from Delta Dental of Wyoming who provides and/or administers my dental benefits and coverage and its authorized service providers at the email address I have provided in this application. These email messages may include protected health information and I understand that because these email messages are not encrypted, there is some risk that the messages could be read by someone other than me. I understand that I am not required to provide this consent. Delta Dental of Wyoming who administers and/or provides my dental benefits and coverage will not condition my eligibility for benefits, treatment, enrollment or payment of claims on whether I provide the consent.

☐ Yes, I consent to receive the above information via email. ☐ No, I do not consent.

Subscriber Signature: _____ Date: _____

Consent to receive text messages containing notifications, tips, reminders, and links to surveys.

I agree to receive automated text messages containing notifications, reminders, tips and links to surveys and information related to my dental insurance for treatment, payment and healthcare operations purposes from Delta Dental of Wyoming who provides and/or administers my dental benefits and coverage and its authorized service providers at the phone number I have provided. These text messages may include protected health information, and I understand that text messages are not encrypted, there is some risk that the messages could be read by someone other than me. I understand that I am not required to provide this consent. Delta Dental of Wyoming, who administers and/or provides my dental benefits and coverage will not condition my eligibility for benefits, treatment, enrollment or payment of claims on whether I provide this consent.

☐ Yes, I consent to receive the above information via text. ☐ No, I do not consent.

Subscriber Signature: _____ Date: _____