For office use:
Alternate ID number

DeltaCare® USA

Delta Dental Insurance Company**
P.O. Box 1803
Alpharetta, GA 30023
888-282-9501 (TTY: 711)

DELTA DENTAL INDIVIDUAL & FAMILY™ DENTAL PROGRAM APPLICATION AND PAYMENT AUTHORIZATION FORM

VERY IMPORTANT - Please Print Legibly. Use black or blue pen.

1. Applicant Information[1]

First Name:		Email Address:	
Middle Initial:		Date of Birth:	
Last Name:		Social Security Number:	
Home Address:		Applicant Contract Facility Name:*	
City:		Applicant Contract Facility Number:*	
State:	Zip:	Gender: ☐ Male ☐ Female	
Phone Number:			

[1] Applicant must be 18 years old or over. If applying to cover children, the applicant must be the parent or guardian and also covered. A person may be covered under only one Delta Dental of California ("DDC") individual policy at a time. If an individual is enrolled to receive benefits as a primary enrollee, dependent enrollee, pediatric enrollee or another similarly defined term under another DDC individual policy, that individual is not eligible to apply for coverage under these dental plans.

2. Dependent Information

Code[2]	Dependent Name	Male or Female	Date of birth	Contract Facility Name*	Contract Facility Number*
		☐ M ☐ F	/ /		
		☐ M ☐ F	/ /		
		☐ M ☐ F	/ /		
		☐ M ☐ F	/ /		
		☐ M ☐ F	/ /		
		☐ M ☐ F	/ /		
		☐ M ☐ F	/ /		
		☐ M ☐ F	/ /		

[2] Code: Place the corresponding character code in the first column to designate each dependent as follows:
Spouse - SP[3] Child - CH Student - STU Disabled Child - DCH

[3] **Spouse:** a person related to or a domestic partner of the Primary Enrollee:
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Policy/Disclosure Form is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Applicant/Primary Enrollee resides.

* I understand that I must select a DeltaCare USA Contract Dentist from the list of dental facilities. If the selected facility is not available, non-contracted or closed to further enrollment, Delta Dental reserves the right to assign me another dental office as close as possible to my home. In the event that Delta Dental cannot assign me to a Contract Dentist, my premium will be refunded.

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that Delta Dental of California's ratio of health care expense to premiums received for the last calendar year was 63%

California law prohibits an HIV test from being required or used by health plans as a condition of obtaining health insurance coverage. For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant: X_____ Date: _____/_____/_____

** In CA, the Delta Dental Individual & Family - DeltaCare USA Program is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.

This Application and Payment Authorization form must be received by the 21st day of the month for your coverage to be effective on the first day of the following month.

3. Program Cost

		Individual & Family Dental Program DeltaCare USA Plan CAA54
☐ Adult annual premium	$107.00 x # adults[4] _____	$_____
☐ Child annual premium	$66.00 x # children[5] _____	$_____
One-time non-refundable Enrollment Fee (required for new enrollment)		$ 10.00
		Total $_____

[4] Applies to Applicant and Dependents (Spouse[3] and Children) 18 years old or over
[5] Dependents (Spouse[3] and Children) under 18 years old

4. Payment Options

You will have the opportunity to renew prior to the end of the Policy term to avoid interruption of coverage.

ONE TIME ANNUAL PAYMENT OPTIONS (choose only one)

➔ **Paper Check**

Please make payable to **Delta Dental of California** and mail completed form to **Accounts Receivable, Delta Dental Insurance Company, P.O. Box 660138, Dallas, TX 75266-0138.**

➔ **Direct Payment/Bank Account**

Type of Account: ☐ Checking ☐ Savings

Account Holder's Name: _____

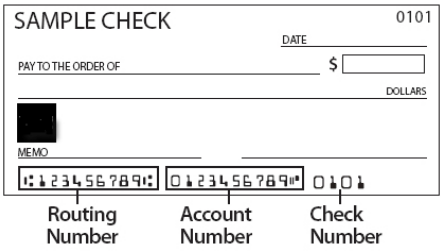
Bank Name: _____

Routing Number (RTN) (9 digits): _____

Account Number: _____

(maximum 10 digits — include leading zeros — do not include check number)

Use information found on your checks



Signature: _____

I hereby authorize Delta Dental, its subsidiaries and affiliates to initiate automatic withdrawal from the account indicated above for the annual premiums due.

Date: _____

Mail completed form to **Delta Dental Insurance Company, P.O. Box 1803, Alpharetta, GA 30023-1803**.

➔ **Credit Card** ☐ Visa® ☐ MasterCard ☐ American Express® ☐ Discover®

Credit Card Number: _____ Expiration Date: _____/_____

Cardholder's Name (as it appears on the credit card): _____

CVV Code:_____ (Visa, MasterCard and Discover: last 3 digits on account number panel on back of card. American Express: 4-digit code printed above account number on front of card)

I hereby authorize Delta Dental, its subsidiaries and affiliates to charge my credit card for the annual premiums due.

Note: Any credit card refunds may be made by check. Signature (required)

Cardholder's Signature: _____ Date: _____

Mail completed form to **Delta Dental Insurance Company, P.O. Box 1803, Alpharetta, GA 30023-1803**.

OPTIONAL: AUTOMATIC RECURRING ANNUAL PAYMENTS

☐ Select and sign below to activate automatic premium payments for future policy renewals (only available for Direct Payment or Credit Card).

I understand and agree to authorize recurring premium payments for my dental plan on an annual basis through Credit Card or Direct Payment method selected above.

If the premium amount changes at renewal, Delta Dental will provide a minimum of 30 days' notice to me.

I understand that these payments will continue until cancellation is submitted. Cancellations can be submitted by me in writing, by phone or by online request. Delta Dental may cancel recurring payments due to invalid, rejected or returned items. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank. If the electronic recurring payment is cancelled upon request by me or by Delta Dental, a new authorization must be completed.

Signature: _____ Date: _____

5. Policy Documents Delivery (Signature Required)

Please check one of the following:

☐ Go Paperless. I have read the Electronic Documents Terms and Conditions (below), and I wish to receive my Policy/ Disclosure Form related documents electronically, when available.

☐ I prefer to receive my Policy/Disclosure Form related documents by U.S. mail.

Signature of Applicant: X_____ Date: _____/_____/_____

Electronic Documents Terms and Conditions

Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your dental Policy/Disclosure Form related documents made available to you electronically. If you choose to have your Policy/Disclosure Form related documents made available to you electronically, the Terms & Conditions below apply.

1. **Communication Methods:** All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental website with your user name and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing."
   You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.

2. **Types of Documents that Will Be Electronically Communicated:** Documents available electronically include, but are not limited to: your application status, your dependent(s) application status, your billing statements, your payment method, your Policy and your claims information.

3. **Requesting Paper Copies:** You can obtain a paper copy of any electronic document by printing it yourself or by requesting that we mail you a paper copy. To request a paper copy, contact our Customer Care. There is no charge associated with requesting a paper copy of a communication we send to you electronically.

4. **How to Withdraw Consent:** You may withdraw your consent to transact business electronically by indicating your preference at our website or by contacting our Customer Care without any charge. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.

5. **How to Update Your Records:** It is your responsibility to provide us with a true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information at our website or by contacting our Customer Care.

6. **Hardware and Software Requirements:** In order to access, view, sign and retain electronic documents that we make available to you, you must:
   - Have a device that will connect to the Internet, access to an email account and access to an Internet browser.
   - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.
   - Be able to view the disclosures on your device.
   - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

6. Agent/Producer Information

(if applicable for Agent/Producer only)

Agent/Producer Name: Jorge Jiron	Are you appointed with Delta Dental? ☐ Yes ☐ No
Agent/Producer License Number:	Agent/Producer Number:
Phone Number: 760-942-7684	Phone Number Type: ☐ Mobile ☐ Home ☐ Business ☐ Other
Email Address: jorge@bestquoteinsurance.net	
Signature:	Date: