



Delta Dental Premier® for Individuals Enrollment Application

Delta Dental of North Carolina

When completing this enrollment application, use an ink pen and print clearly. If information is missing or illegible, this form may be returned and it can delay your enrollment. For information or assistance in completing this form, call Customer Service at 1-866-280-8379. Send completed application to: Delta Dental of North Carolina ♦ Attn: Enrollment Department ♦ PO Box 9342 ♦ Minneapolis MN 55440-9342.

PART A – SUBSCRIBER INFORMATION

Subscriber's Name:	Last	First	Middle Initial	Social Security Number / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Day Phone Number	Evening Phone Number	Email Address	Date of Birth / /
Subscriber's Address:	Address			
	City	State	Zip Code	
Agent Information:	Agent Name	Agency Name	Agent Phone Number	

PART B – ENROLLMENT OPTIONS

Select One Plan Option: **Plan A** (\$75 Deductible/\$1000 Plan Maximum) **Plan B** (\$75 Deductible/\$1000 Plan Maximum)
 Plan C (\$50 Deductible/\$500 Plan Maximum) Note: Covered services and coinsurance levels vary between Plans.

Select Who Is To Be Enrolled: Subscriber Only Subscriber + One Dependent Family (Three or More)
 Note: Must be 18 years or older to enroll as a subscriber and not covered under a Delta Dental of North Carolina employer group plan.

Complete this section if you have selected the enrollment option of Subscriber + One Dependent or Family. If more than four family members are being enrolled, attach a list of additional dependent information in the below format. Dependent children age 19-25 must be full-time students to be eligible.

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
		M	F		Y	N	Y	N
Spouse		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

PART C – PAYMENT OPTION INFORMATION – Select payment option and billing frequency.

Select One Payment Option and Billing Frequency

A. Direct Withdrawal from Checking Account: Monthly Quarterly Annual
 Name on Checking Account: _____ Bank Name: _____
 Routing Number: _____ Checking Account Number: _____
 The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.

B. Check: Quarterly Annual Send this form and a check payable to Delta Dental of North Carolina. Future premiums will be billed prior to the start of each coverage period.

PART D – AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I have read the information contained in the application and choose to enroll. I understand the benefits and restrictions of this plan as stated in the material provided with the application. I certify the information contained in this application is true and complete. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages. I understand my enrollment is subject to receipt of payment and verification of funds. The start and cancellation dates of my insurance coverage will be determined by Delta Dental of North Carolina. The start date is generally the first day of the month following receipt of the enrollment application. If I have selected Payment Option A, I authorize Delta Dental to withdraw funds from my checking account. I understand that if funds/credit balances are not available or payment is not made timely 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 that I must enroll for one full year and if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of two years.

Subscriber Signature: _____ **Date:** _____