DELTA DENTAL®

Individual Plan Application

SUBSCRIBER INFORMATION

Name: _____ Phone: _____

Address: _____ SSN: _____

City: _____ State: _____ ZIP: _____ Birth date: _____

BENEFIT SUMMARY FOR BOTH PLANS

	Delta Dental PPO	Out-of-network	Waiting Periods
Diagnostic and Preventive	100%*	80%*	None
Sealants	80%	60%	None
Basic Services	80%	60%	None
Fillings	80%	60%	6 months
Endodontics	50%	40%	6 months
Periodontics	50%	40%	6 months
Oral Surgery	50%	40%	6 months
Major Restorations	50%	40%	12 months
Prosthodontics	50%	40%	12 months
Implants	50%	40%	12 months
Contract Year Maximum		$1,000 per member	
Individual Deductible		$50 per contract year	
Family Deductible		$150 per contract year	

*Deductible does not apply to in-network diagnostic & preventive services. *Co-pay option requires $20 office visit co-pay for diagnostic & preventive services.*

PREMIUM OPTIONS:	STANDARD		CO-PAY	
	Monthly	Annual	Monthly	Annual
Individual	$32.78	$393.36	$29.99	$359.88
Ind. +1 dependent	$62.44	$749.28	$56.99	$683.88
Ind. +2 or more dependents	$110.11	$1,321.32	$99.99	$1,199.88

Note: For monthly billing option, add $1.50 monthly billing fee to premium. Avoid this fee by paying annually.

SELECT PLAN AND PAYMENT METHOD

Select a plan (choose one): ☐ Standard ☐ Co-pay

Select method of payment (choose only one):

☐ Check (annual only) Make check payable to **Delta Dental of Tennessee**

☐ Monthly credit card
☐ Annual credit card
Visa/MasterCard *(please circle one)* Account number Exp. date (MMYY)

☐ Monthly bank draft
☐ Annual bank draft
Bank name: _____
Account #: _____
Routing #: _____

DEPENDENTS TO BE COVERED (IF ANY)

Name	Birth date	SSN	Relation (spouse or child)

CERTIFICATION AND AGREEMENT

This is to certify that the information contained in this application is true, complete and accurate. It is understood that the rates, terms, and conditions of any related contract issued by Delta Dental of Tennessee (DDTN) shall be based upon the representations in this application and other information previously provided to DDTN. It is further understood that if any information or representation is not true, complete or accurate, that DDTN may adjust the rates, terms or conditions and/or cancel any contract. Furthermore, you certify that you are applying for this policy in the State of Tennessee. This application shall become a part of the contract issued by DDTN. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of coverage.

Individual hereby agrees that if DDTN accepts this application and issues a signed contract, the Individual shall be bound by the terms and conditions of said contract. Individual further agrees to pay the premiums defined in said contract in accordance with the terms of said contract. Individual also recognizes that this contract may only be modified by written document issued by DDTN as defined in the contract.

I hereby authorize DDTN, its subsidiaries and affiliates to charge my credit card or to initiate automatic withdrawals (ACH) from my account, as indicated on this application, for premiums due. This authorization will remain in effect until DDTN has received written notice from me of its termination and/or my payment obligation has been satisfied. If the billing amount changes, DDTN will provide a minimum of 10 days' notice to the cardholder, if applicable. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank, if applicable.

Signature _____ Date _____

Printed name _____

How did you hear about this plan? _____

Broker name (if any) Stephen Addison Koella

Broker confirmation email address akoella@herronconnell.com

Mail completed application to: Delta Dental of Tennessee
6607 Collection Center Drive
Chicago, IL 60693