Application for Individual & Family Plans from Delta Dental

I am applying for:

- ☐ GrinWell *Prime*[SM]
- ☐ GrinWell *Plus*[SM]
- ☐ Clear Plan[SM]
- ☐ GrinWell *Essential*[SM]
- ☐ GrinWell *Prevent*[SM]

Please send completed application to:
Delta Dental of Idaho
555 E. Parkcenter Blvd
Boise, ID 83706

PLEASE PRINT CLEARLY

First Name	MI	Last Name	Gender: ☐ Male ☐ Female ☐ Other	Date of Birth

Social Security Number:				
Mailing Address	City	State	Zip	Phone # (with area code)
E-mail Address*				

** By providing my email address, I agree to receive communications regarding my Policy electronically. This authorization may be revoked by calling Customer Service at (800) 356-7586.*

PLEASE LIST ALL PERSONS TO BE COVERED UNDER THIS POLICY

Relationship to Applicant	SSN#	Dependent's Name (First, MI, Last)		Date of Birth (mo/day/year)
☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female ☐ Other	
☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female ☐ Other	
☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female ☐ Other	
☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female ☐ Other	
☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female ☐ Other	
☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female ☐ Other	
☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female ☐ Other	

PRIOR DENTAL COVERAGE

Name of Carrier	Policy #	Name on Policy	Start Date of Coverage	End Date of Coverage

Add additional sheets of paper as necessary for more family members.

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Payment instructions

To calculate rates please visit **www.deltadentalid.me** or call **(855) 70-DELTAID**. Rates remain fixed for the one year contract period.

All premiums must be paid electronically using your checking/savings account or credit card.

Choose your payment method: ☐ EFT ☐ Credit Card

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

Name of Financial Institution: _____

Financial Institution's City, State & Zip Code: _____

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.

I understand that any EFT transaction that is dishonored by my financial institution intended for payment to Delta Dental of Idaho may be assessed a $35 service charge by Delta Dental of Idaho.

Please complete the following information for payment by Credit Card:

Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Name on card: _____

Card Number: _____

Expiration Date: Month: _____ Year: _____ Card security code (CSC): _____

Billing address *(if different than mailing address):* _____

City: _____ State: _____ Zip: _____

Annual contract required - sign and date to authorize payment:

I hereby authorize Delta Dental of Idaho to initiate debit entries from my above bank account/credit card for my premiums.

Drafts will be made on the 20th of each month and applied to the next month's premium.

Signed: _____ Date: _____

In making this application to Delta Dental of Idaho for dental coverage under this program, I agree and understand that this application will become part of the Contract and I agree to be bound by the terms of the Contract issued by Delta Dental of Idaho. I further agree that the coverage requested is subject to the approval of Delta Dental of Idaho and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Contract to be null and void. I understand contracts are for a one year period.

When valid enrollment documentation and payment are received on the 1st through the 15th day of the month, coverage will become effective the first day of the next month. When valid enrollment documentation and payment are received on the 16th through the last day of the month, coverage will be effective the first day of the second month. Coverage is contingent upon underwriting acceptance.

_____ _____

Applicant Signature Date

FOR AGENT USE ONLY

Agency Code: _____

Agent Name: _____

Note to agents:

For commission to be paid accurately, it is vital that you enter the correct agency code assigned to you by Delta Dental of Idaho in the space indicated. If you are not sure of the agency code that has been assigned to you, contact your Delta Dental sales representative before submitting this application.

Delta Dental of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(800) 356-7586.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-(800) 356-7586.