



INDIVIDUAL ENROLLMENT/CHANGE APPLICATION

This application form must be received by Delta Dental of Iowa 10 days prior to the effective date. The effective date is always 1st of the month.

Product Choice: <input type="checkbox"/> Preventive <input type="checkbox"/> Preferred Choice		Social Security No. _____	Effective Date ____/____/01____
<input type="checkbox"/> New Applicant <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name/Address Change			

SECTION I	Name (First, Middle Initial, Last) _____	Telephone () _____	Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Complete Address – Street City State Zip	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other (specify) _____		
E-mail address: _____		Please check the coverage you are applying for: <input type="checkbox"/> Single <input type="checkbox"/> Two-person <input type="checkbox"/> Family		

SECTION II ELIGIBLE DEPENDENTS

List eligible members of your family to be covered			Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
First Name	Middle Initial	Last (if different)						
Spouse				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Disabled? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Other Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete: **Contract holder:** _____

_____/____/____ Single Family

Name of other dental carrier **Policy Number** **Effective Date** **Contract type**

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes:

Marriage Death Divorce Birth/Adoption Drop Dependents Terminating Benefits
 Other (explain) _____ **Name of Affected Party** _____ **Date of Event** _____

SECTION IV AGREEMENT and CERTIFICATION

I have read and understand the Agreement and Certification of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE

Applicant Signature

_____/____/____
Date

_____/____/____ KHI Financial Solutions _____
Agent Name / Agency * NPN Insurance License #

Internal Use Only Agency ID# _____
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*This is the agency authorized by Delta Dental of Iowa to sell individual dental products.

