DELTA DENTAL

IBEW Local 369 Enrollment Form

Please select the plan in which you would like to enroll.

☐ *Delta Dental PPO Dental Coverage with VSP Vision Plan Included*

☐ *Delta Dental PPO Dental Coverage Only*

☐ *VSP Vision Plan Only*

Please complete the information below. You must be a Kentucky resident to enroll.

Social Security Number	Name – Last	First	MI	Home Phone ( )

Sex (Circle one) M or F	Date of Birth MO DAY YR	Home Address – Number and Street	City	State	Zip
				KY	

Check the type of contract and list all covered dependents below, if applicable:

❑ **Employee only** ❑ **Employee plus Spouse** ❑ **Employee plus Child(ren)** ❑ **Family**

COVERED DEPENDENTS List all Covered Dependents below. If additional space is required, attach a list to this form.

Last	First	MI	Date of Birth MO	DAY	YR	Sex M	F
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

Dependents covered through age 26.

Please select one of the payment methods below. Please provide all necessary information.

1. Credit Card – ❑ **Annual** ❑ **Monthly**

❑ **Visa** ❑ **MasterCard** ❑ **Discover** ❑ **American Express**

Card Number_____

Expiration Date _____

Signature _____

Annual credit card payments will be automatically withdrawn from your account at your renewal.

2. ❑ **Paper Check or Money Order – Annual premium only**

Please include your check or money order with this form.

3. ❑ **Bank Draft – Monthly premium only**

A) Please complete the enclosed "Did You Know?" authorization form or send a voided check with this form in order to accurately establish your new withdrawal. The draft process will originate from our office between the **4th and the 6th of each month** and should reach your account for processing within three working days. First month premium not required.

B) Monthly bank drafts will remain in full force and effective until Delta Dental of Kentucky and your bank (depository) have received written notification from you of termination and in such time and in such manner as to afford the depository a reasonable time to act on it.

Please carefully read the Contract Provisions on the back of this form. Signature required. Please review your enrollment form for errors or omissions.

® Registered Marks Delta Dental Plans Association

Please carefully read the Contract Provisions below. Signature required.

Contract Provisions

IMPORTANT: If you do not want the contract for any reason, you may return it to us within 10 days after you receive it. Upon return, the contract will be deemed void, and any money you have paid will be refunded.This is an annual contract. If you have elected the annual payment option, you may not terminate this contract prior to the end of the term. If you have elected the monthly payment option and we do not receive your premium within 30 days of the date the premium is due, your contract will be cancelled effective the due date of your premium, whether or not a specific condition was incurred prior to the termination date. Your Covered Dependents will terminate on your termination date. Covered Services are eligible for payment only if your contract is in effect at the time such services are provided.

I acknowledge that I have read the provisions of this enrollment form and I expressly accept such provisions as a condition of coverage. I understand that my membership is for a 12-month period and on my anniversary date I can renew or cancel or change how I pay my premium. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Delta Dental of Kentucky, Inc. in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this form, the dental contract, and the identification card will constitute the contract.

Applicant Signature_____ Date _____

Call 1-855-308-2299 to enroll over the phone

or

Complete this enrollment form and mail to:

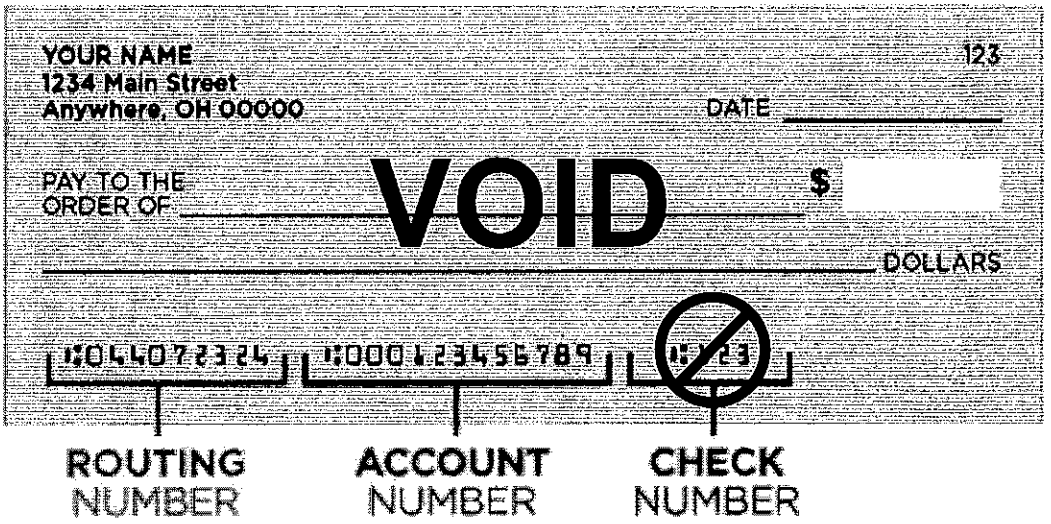
Delta Dental of Kentucky, Inc.
32165 Collection Center Drive
Chicago, IL 60693-0321

DELTA DENTAL

DID YOU KNOW?

Delta Dental can automatically debit your monthly payment from a checking or savings account.

If you would like to be set up for the automatic debit process, please fill out the form below, attach a copy of your blank voided check and mail it with your enrollment form.



Bank Name: _____

Account Holder Name: _____

❑ Checking Account

❑ Savings Account

_____ _____

Bank Routing Number | Bank Account Number

Please do not include the check number.

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until I choose to not to renew my contract with Delta Dental or change payment methods.

Name on account (please print): _____

Account Holder Signature: _____ Date: _____