DELTA DENTAL

Application for Individual Dental Insurance

PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL

Delta Dental of Wisconsin
P.O. Box 828
2801 Hoover Road
Stevens Point, WI 54481
www.deltadentalwi.com

1. LAST NAME:		2. FIRST NAME:		
3. HOME ADDRESS:	4. CITY:	5. STATE:	6. ZIP:	7. PHONE NUMBER (with area code)
8. EMAIL ADDRESS:		9. DATE OF BIRTH:		10. GENDER: M/F

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY

11. FIRST NAME	12. LAST NAME (If different from Subscriber)	13. DATE OF BIRTH	14. GENDER M/F	15. Check if Dependent is over 19 and a full-time student.
SPOUSE:				
CHILDREN:				

16. REASON FOR SUBMISSION: ☐ New Enrollment ☐ Change of Dependent(s) ☐ Change in Enrollment (Single/Family Plan)

17. If coverage under this policy is through membership in an association, please provide the name of the association:

18. Will this policy replace an existing in-force dental benefits policy? ☐ Yes ☐ No (If you selected yes, please provide the name of the existing dental carrier)

PAYMENT INSTRUCTIONS: I will be paying my premium on a monthly basis

19. I WILL BE PAYING MY PREMIUM BY: ☐ Check ☐ Automatic withdrawal from my bank account (ACH)

If paying by check: Please make your check payable to Agri-Services Agency. and mail your first premium payment with this application.

If paying by ACH: Please complete the following information:

Type of Account (Choose one) ☐ Checking ☐ Savings Name on Account _____

Bank Routing Number _____ Bank Account Number _____

Please attach a voided check to this application.

I hereby authorize Agri-Services Agency to debit my above bank account for my dental insurance premiums.

20. Signed: _____ Date: _____

Agri-Services Agency will accept premium payments on behalf of Delta Dental of Wisconsin, Inc.

In making this application to Delta Dental of Wisconsin, Inc., (DDW), for dental coverage under this program, you agree and understand that this application will become part of the Policy and you agree to be bound by the terms of the Policy

issued by DDW. You further agree that the coverage requested is subject to the approval of DDW and that no agent or representative has authority to make changes or modify this application for coverage. You hereby certify that all of the information contained in this application is true and correct to the best of your knowledge. Misrepresentation of submitted data will cause this application and subsequent Policy to be null and void.

Your Policy will become effective on the first day of the month following approval of your application.

21. Subscriber Signature _____ Date _____

Approval of coverage is contingent upon underwriting acceptance.