DELTA DENTAL®

Delta Dental Individual & Family Plan Enrollment/Change Form

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

Enroll online now at www.mysmilecoverage.com/nm or complete this form and mail it to:

Delta Dental of New Mexico
Individual Product Unit
P.O. Box 1596
Indianapolis, IN 46206

Delta Dental Use Only:
For plans #87109, #87110 and #87111

For help filling out this form, please contact the Individual Product Unit at (800) 971-4108.

☐ **New Enrollment:** Check for first-time enrollment.
☐ **Change/Correction to Information:** Check if any changes are being submitted on this form.
☐ **Termination of Benefits:** Check only if you are terminating coverage for you and/or your dependents.

Will this Policy replace or change an existing policy of dental insurance?* ☐ Yes ☐ No

If yes, please describe:

*Delta Dental may choose to waive applicable Benefit waiting periods if you had recent fully insured dental coverage. Please contact the Individual Product Unit at (800) 971-4108 for more information.

Part A – Insured's Information

Insured's Name (First, Middle Initial, Last)	**E-mail Address** (Optional)
Date of Birth (MM/DD/YYYY)	**Social Security Number**
Street Address (Including City, State, ZIP Code)	☐ **Check here if new address**
Telephone Number	**Coverage Effective Date**** (MM/DD/YYYY)

**The date coverage takes effect for you and/or your dependents. This date must be on the first day of a month, and may be as early as the first day of the month following the month in which your application is approved.

Part B – Spouse or Domestic Partner's Information

Spouse or Domestic Partner's Name (First, Middle Initial, Last)	
Date of Birth (MM/DD/YYYY)	**Social Security Number**

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Part C – Dependent Child Information

#1 – Dependent Child's Name (First, Middle Initial, Last)

Date of Birth (MM/DD/YYYY)	**Social Security Number**

#2 – Dependent Child's Name (First, Middle Initial, Last)

Date of Birth (MM/DD/YYYY)	**Social Security Number**

#3 – Dependent Child's Name (First, Middle Initial, Last)

Date of Birth (MM/DD/YYYY)	**Social Security Number**

#4 – Dependent Child's Name (First, Middle Initial, Last)

Date of Birth (MM/DD/YYYY)	**Social Security Number**

#5 – Dependent Child's Name (First, Middle Initial, Last)

Date of Birth (MM/DD/YYYY)	**Social Security Number**

Part D – Plan Selection and Rates

The amount payable for coverage varies based on the coverage option selected, the age of the Enrollee, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling.

	High Plan	Graduated Dental Plans		Standard Dental Plans	
Rating Tiers	☐ **Chile Plan (Delta Dental PPO™ Point of Service)**	☐ **Coral Plan (Delta Dental PPO™)**	☐ **Turquoise Plan (Delta Dental PPO Point of Service)**	☐ **Core Plan (Delta Dental PPO)**	☐ **Enhanced Plan (Delta Dental PPO Point of Service)**
Subscriber Only (Monthly/ Annual)	$43.01/ $516.12	$28.28/ $339.36	$39.40/ $472.80	$25.20/ $302.40	$35.05/ $420.60
Subscriber + 1 (Monthly/ Annual)	$82.05/ $984.60	$54.29/ $651.48	$75.64/ $907.68	$48.12/ $577.44	$67.18/ $806.16
Subscriber and Family (Monthly/ Annual)	$134.14/ $1,609.68	$93.03/ $1,116.36	$129.62/ $1,555.44	$78.90/ $946.80	$111.87/ $1,342.44

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Part E – Payment Frequency and Method

Payment Frequency

☐ **Annual** (Payable by check, credit card, and automatic withdrawal. If you are paying by check, you **must** choose this option.)

☐ **Monthly** (Payable by credit card and automatic withdrawal.)

☐ **Check payable to Delta Dental of New Mexico** (You may pay by check only if you choose an annual payment.)

☐ **Credit Card Payment (Choose One):** ☐ MasterCard ☐ VISA ☐ Discover

Card Number	**Expiration Date** (MM/YYYY)

Cardholder's Name (As It Appears On Card)	**CVV Code** (Last Three Digits on the Back of Your Credit Card)

Credit Card Billing Address (If Different from Mailing Address - Including Street Address, City, State, ZIP Code)

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for Premium due. This authorization will remain in effect until Delta Dental has received written notice from me of its termination. If the billing amount changes, Delta Dental will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature_____Date_____

☐ **Automatic withdrawal from bank account**

Bank Name	**Account Type** ☐Checking ☐Savings

Routing Number	**Account 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 Delta Dental has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature_____Date_____

Part F – Validation Question, and Signature

Validation Question (Choose ONE and Answer Below)

☐ Mother's maiden name (last name only) OR ☐ City in which you were born OR ☐ Name of first pet

Answer to Validation Question

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Any person who knowingly presents a false or fraudulent claim for payment of a loss or Benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Applicant's Signature _____Date_____

Please mail enrollment form (and check, if applicable) to:
Delta Dental of New Mexico
Individual Product Unit
P.O. Box 1596
Indianapolis, IN 46206

Agent Use Only (If Applicable)	
Agent's Name	**Agency Name**
National Producer Number (NPN)	**Phone Number**