

# Individual Dental Insurance

From Delta Dental of Iowa



Our individual dental plans put the coverage in your hands with access to the largest dentist network in Iowa.

## With Delta Dental, there's no reason to be without dental insurance.

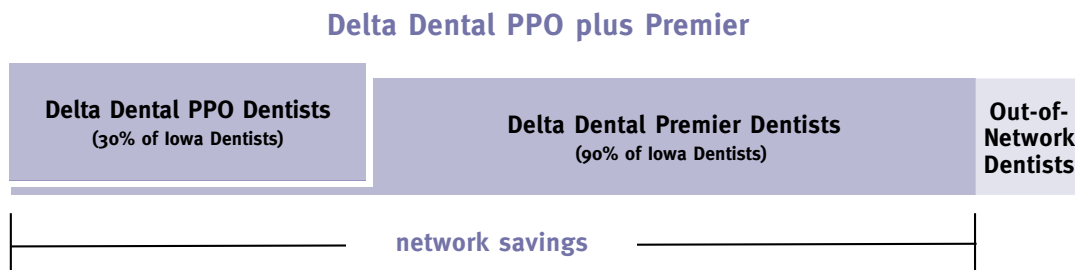
Individual dental insurance from Delta Dental of Iowa has it all. Flexible coverage options. The freedom to select the dentist of your choice. Affordable rates with automatic monthly withdrawals. Plus, the outstanding customer service provided by Iowa's largest dental benefits provider.

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### Delta Dental's Two Networks

Our individual plans are based on the Delta Dental PPO<sup>SM</sup> network. In most cases, you will receive a richer benefit and have lower out-of-pocket expenses when you see a Delta Dental PPO dentist. You have the flexibility to choose a larger network of dentists by using the Delta Dental Premier<sup>®</sup> or a non-participating dentist.

More than 30 percent of the dentists in Iowa participate in the Delta Dental PPO network, while more than 90 percent of the dentists participate in the Premier network. For a complete list of participating Delta Dental dentists in your area go to [www.deltadentalia.com](http://www.deltadentalia.com).



### Choose The Plan That Fits Your Needs

#### Preferred Choice Plan

This plan has a focus on preventive services by waiving deductibles for check-ups and cleanings, while providing coverage for major dental services in one plan. The Preferred Choice plan includes:

- 100% coverage for check-ups, cleanings and x-rays from Delta Dental dentists.
- Check-ups and cleanings do not apply to your deductible.
- Oral surgery, tooth extractions and most major services are covered.

Plans open to Iowa residents only.

#### Preventive Plan

This plan focuses on oral health preventive care and includes savings on routine and restorative services.

The Preventive plan includes:

- Routine check-ups, x-rays and cleanings.
- Savings for routine and restorative services.

#### Contact Us

For more information on Delta Dental's individual dental coverage, contact your local health insurance agent or Delta Dental of Iowa at 877-423-3582 ext. 3.

## Choose the Individual Plan that Fits Your Needs

Preferred Choice Plan	Delta Dental PPO <sup>SM</sup> Dentist	Delta Dental Premier <sup>®</sup> Dentist	Non-Participating/ Out-Of-Network Dentist
<b>Deductible per person per calendar year</b>	\$50	\$150	\$225
<b>Diagnostic and Preventive</b> • Check-ups and Teeth cleanings* (2 per calendar year) • X-rays	100% 100%	100% 100%	50% 50%
<b>Routine and Restorative Services</b> • Fillings • Tooth Extractions • Oral Surgery	50% 50% 50%	50% 50% 50%	30% 30% 30%
<b>Endodontics – 6-month waiting period</b> • Root Canals	50%	50%	30%
<b>Periodontics – 6-month waiting period</b> • Gum and Bone Disease	50%	50%	30%
<b>Major Restorative Services – 12-month waiting period</b> • Crowns • Dentures • Bridges	50% 50% 50%	50% 50% 50%	30% 30% 30%
<b>Annual Benefit Maximum per person per calendar year</b>	\$1,000	\$1,000	\$1,000

### 2010 Monthly Premiums

Single	\$36
Two-Person	\$72
Family	\$100

Percentages shown are what Delta Dental pays. For example, if Delta Dental pays 100%, your coinsurance is 0%.  
\* Deductible waived for exams and teeth cleanings under the Preferred Choice plan.

Preventive Plan	Delta Dental PPO <sup>SM</sup> Dentist	Delta Dental Premier <sup>®</sup> Dentist	Non-Participating/ Out-Of-Network Dentist
<b>Deductible per person per calendar year*</b>	\$50	\$50	\$75
<b>Diagnostic and Preventive</b> • Check-ups and Teeth cleanings (2 per calendar year) • X-rays	80% 80%	70% 70%	50% 50%
<b>Routine and Restorative Services**</b> • Fillings	50%	50%	30%
<b>Annual Benefit Maximum per person per calendar year</b>	Unlimited	Unlimited	Unlimited

### 2010 Monthly Premiums

Single	\$18
Two-Person	\$35
Family	\$64

Percentages shown are what Delta Dental pays. For example, if Delta Dental pays 80%, your coinsurance is 20%.

\* Deductible applies to all covered services under the Preventive Plan.

\*\* Extractions and oral surgery are not covered under the Preventive Plan.

There is a 24-month waiting period to re-enroll if coverage is dropped. Subsequent rate changes will be reviewed annually with a January 1 effective date subject to 60-day notification. Applications must be received by the 20th of the month to be effective the 1st of the following month. Applications received after the 20th will be effective the first of the next month.

## We love to see *your* smile.®

At Delta Dental of Iowa, we are passionate about oral health and its importance to generations of families. For almost 40 years, we have worked to improve oral health by emphasizing preventive care and making dental coverage accessible to a wide variety of employers, groups and individuals.

Ask your health insurance agent for more information about our individual dental insurance plans designed for Iowans like you.



Delta Dental of Iowa  
2401 SE Tones Drive, Suite 13  
Ankeny, IA 50021  
877-423-3582 ext. 3  
515-261-5600

[www.deltadentalia.com](http://www.deltadentalia.com)



# 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 1<sup>st</sup> of the month.

Delta Dental of Iowa  
PO Box 788  
Ankeny, Iowa 50021-0788  
[www.deltadentalia.com](http://www.deltadentalia.com)  
1-877-983-3582  
Fax: 888-264-1433

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

<b>SECTION I</b>	<b>Name (First, Middle Initial, Last)</b>	<b>Telephone</b> ( )	<b>Date of Birth</b> ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<b>Complete Address – Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>

**Status:**  Single  Married  
 Other (specify) \_\_\_\_\_

**E-mail address:** \_\_\_\_\_

**Please check the coverage you are applying for:**  
 Single  Two-person  Family

**Please let us know how you heard about Delta Dental of Iowa's Individual Dental Product.**

Newspaper Ad  Dentist Office  Internet  Other Media Ad  Friend / Relative  Other \_\_\_\_\_

## 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
Dependent				____/____/____	<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
Dependent				____/____/____	<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
Dependent				____/____/____	<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
Dependent				____/____/____	<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

## AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for individual coverage offered by Delta Dental of Iowa. I understand that I am responsible to pay monthly premium charges to Delta Dental of Iowa for this coverage, and if payment is not made when due, my coverage is subject to termination. I further understand that should this coverage be terminated, either voluntarily or involuntarily, I will not be eligible to apply for individual coverage offered by Delta Dental of Iowa for a period of 24 months from the date of termination. I understand that coverage for the dental care policy applied for will not start until after this application **and the required monies for premium are received** and accepted by Delta Dental of Iowa and an effective date is established by Delta Dental of Iowa. I understand that written notice of rate changes will be furnished by Delta Dental of Iowa at least 60 days prior to the effective date of any such rate change.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental of Iowa will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental of Iowa will be entitled to declare the dental care policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental of Iowa when reasonably related to the dental care coverage for which I have applied. If any law or regulation requires additional authorization for release of dental records, I will give this authorization.

***To cancel coverage, Delta Dental of Iowa requires at least a 20-day written notice prior to the requested termination date to insure the automatic payments can be discontinued.***

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### DELTA DENTAL OF IOWA ACCOUNT WITHDRAWAL AUTHORIZATION - REQUIRED

I (we) hereby authorize Delta Dental of Iowa to initiate debit entries to the account indicated below, and the financial institution named below, to debit the same to such account.

This authorization is for the purpose of paying monthly premiums for Delta Dental benefits, and I understand that the amounts are subject to change upon prior written notification to me at least 30 days in advance of any rate adjustment.

**Monthly Withdrawal Date:**                      1st of month                      5<sup>th</sup> of month

**Bank Information:**

\_\_\_\_\_  
Name of Financial Institution                      Branch (if applicable)

\_\_\_\_\_  
Address of Financial Institution                      City                      State                      Zip Code

**Account Type:**

- Checking – please attach a **voided check** (deposits slips are NOT acceptable for checking account information)
- Savings – please attach a pre-printed deposit slip and indicate for savings account only:  
Bank Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

This authority is to remain in full force and effect until Delta Dental of Iowa has received written notification from me (us) of its termination. **Delta Dental requires a minimum of 20 days advance notice for termination of coverage in order to afford Delta Dental and the above named financial institution sufficient opportunity to process.**

I certify to the best of my knowledge that the banking information given above is not that of a foreign banking institution (located outside of the United States).\*

\_\_\_\_\_  
Please Print Name of Insured                      Delta Dental ID Number (Social Security Number)

\_\_\_\_\_  
Signature of Insured                      Date Signed

\*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions.

**Please return this completed form along with your application for coverage.**

<b>Please return the completed form to: Delta Dental of Iowa PO Box 788 Ankeny, Iowa 50021-0788</b>	<b>Or Fax to: 888-264-1433</b>
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Have you attached a voided personal check or a pre-printed personal savings account deposit slip from your financial institution?