



Individual Dental Enrollment Application

Please complete both sides of this form and sign on the back. Please type or print legibly in dark blue or black ink.

Applicant name (first, middle initial, last)		Birthdate	Gender	Applicant Social Security no.
Applicant mailing address		City	State	ZIP
E-mail address		Home telephone no.		
		Primary language: <input type="checkbox"/> English <input type="checkbox"/> Spanish		
		<input type="checkbox"/> Other _____		
Choose a plan: <input type="checkbox"/> Delta Dental Premier plan <input type="checkbox"/> Delta Dental Preferred Provider Option (PPO) plan				

Are you a resident of Oregon? Yes No

(In order to be eligible to enroll in this plan, you must be an Oregon resident and live in Oregon for at least six (6) months out of the year.)

Dependent information (Dependents must have been covered under prior group plan in order to be eligible for continuation.)			
Name (first, middle initial, last)	Birthdate	Gender	Social Security no.
Spouse/Registered domestic partner*		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	

*Registered domestic partner according to the Oregon Family Fairness Act.

Type of application

New enrollment

This application for dental insurance coverage is for:

Insured only

Insured + spouse or registered domestic partner*

Family

Insured + child(ren)

Individual Dental eligibility requirements

You are eligible for individual dental coverage under this agreement if you meet the following requirements:

- You are an Oregon resident and live in Oregon at least six months out of the year.
- If you terminate this coverage you will be required to wait two years before you may re-apply with a maximum of two re-applications per member per lifetime on either plan.
- Any new enrollment will begin at the first-year benefit level.
- When you move from our Individual Options dental rider to this plan, you may retain your benefit level as long as there is no lapse in coverage and your application is received within 30 days.

ODS Individual Dental enrollment application *It is very important that you sign and date below.*

Billing information: choose one option

Monthly premium: Insured only: [] Insured + spouse: [] Family: [] Insured + children: []

Option 1: Auto Pay plan (checking account deduction)

Bank name: _____ Branch: _____

Bank address: _____ Bank account no.: _____

This authority is to remain in full force and effect until ODS and my bank have received written notifications from me of its termination in such time and in such manner as to afford ODS and my bank a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such an error to the bank within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

- Attach a check for one month's premium made payable to ODS, or indicate here if you want the initial premium drafted. Yes No
- Attach a "voided" check from which you want the payment withdrawn.
- Funds will transfer on or around the fifth calendar day of each month.

Signature: _____ Date: _____

Option 2: Monthly billing statement

- A \$5 monthly administration fee is required with this payment method.
- Attach a check or money order for one month's premium made payable to ODS. A bill will be sent in the mail every month.

Option 3: Quarterly billing statement

- A \$5 quarterly administration fee is required with this payment method.
- Attach a check or money order for three months' premium made payable to ODS.

For agent use only — reminder: collect premium with application

I, (the Agent) certify I have explained the eligibility provisions to the Applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by ODS, and provided Oregon Disclosure Information required. I CERTIFY THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent name (please print or type): _____

Agency name: _____ Telephone no.: _____

Street address: _____ City: _____ State: _____ ZIP: _____

Agent signature (required): _____ Date: _____

Applicant signature

I understand mailing a check to ODS does not guarantee coverage and that complete submission is required no less than 10 days before the desired effective date in order to process this application. If my application does not otherwise meet the eligibility requirements as stipulated, ODS will notify me in writing and my payment will be returned.

Signature: _____ Date: _____

(or signature of minor's representative for any applicant under age 18)

Insurance products provided by Oregon Dental Service

ODS ELIGIBILITY DEPARTMENT • 601 S.W. SECOND AVENUE • PORTLAND, OR 97204
503-265-5696 • 800-852-5195, ext. 5696 • www.odscompanies.com

