DELTA DENTAL

Application

Mail completed form with payment to:

Delta Dental of California, Enrollment and Billing Department

P.O. Box 1870

Alpharetta, GA 30023

Form must be received by 21st day of the month in order for coverage to be effective on the first day of the following month.

A. Applicant

Applicants must be 18 and over.

App	Test	K
Last Name	First Name	MI
05/05/1971	***-**-6021	Male
Date of Birth MM/DD/YYYY	Social Security Number	Sex M/F

100 1st St Rivoli Pleasanton

Street Address

San Francisco	CA	94105
City	State	Zip
987-654-3210	test@gmail.com	
Daytime Telephone	Email Address	

B. Dependents

Complete this section if you are enrolling your spouse, partner and/or your dependents.

Relationship	First Name	Last Name	Sex M/F	Date of Birth MM/DD/YYYY	Disabled? Yes/No
Spouse/Partner:	firstName	lastName	Female	05/10/1995	
Child:	firstChild	lastNamefirstChild	Female	05/10/2001	No
Child:					
Child:					
Child:					

For assistance in competing this application, call toll-free 1-800-585-0468.

(continue on next page)

C. Plan Cost and Payment Options

Please check your preferred billing frequency, plan option and payment method below.

Plan Option
Select one: ☑ Basic PPO ☐ Premium PPO

Billing Frequency
If you choose monthly, your initial payment will include your first two months' premium.

Select one: ☑ Monthly ☐ Quarterly ☐ Annual

Plan Cost	Basic PPO		Premium PPO	
Billing Frequency	Age 18 or older	Age 0-17	Age 18 or older	Age 0-17
Monthly	$ 33.91	$ 28.25	$ 66.97	$ 43.89
Quarterly	$ 101.73	$ 84.75	$ 200.91	$ 131.67
Annually	$ 406.92	$ 339.00	$ 803.64	$ 526.68

☑ Age 18 or older $33.91 x # 2 $ 67.82

☑ Age 0-17 $28.25 x # 1 $ 28.25

One-time non-refundable Enrollment Fee (required for new enrollment) $ 10.00

Total $ 202.14

Payment Method

Select one:

Direct Payment/Bank Account

Type of Account: ☐ Checking ☐ Savings

Account Holder's Name: _____

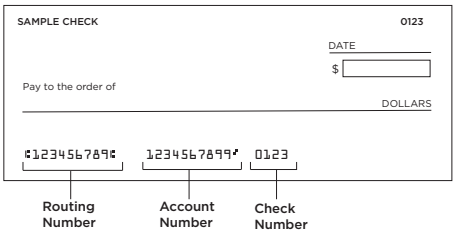
Bank Name: _____

Account Number: _____

(maximum 10 digits — include leading zeros — do not include check number)

Routing Number (RTN) (9 digits): _____

Use information found on your checks



I hereby authorize Delta Dental, its subsidiaries and affiliates to initiate automatic withdrawal from the account indicated above for the premiums due.

Signature: _____ Date: _____

Credit Card

☐ Visa® ☐ MasterCard ☐ American Express® ☑ Discover®

Cardholder's Name (as it appears on the card): Peter Heins

Credit Card Number: **********3331

Expiration Date: 05 / 2020 CVV Code: _____

(Visa, Mastercard and Discover: last 3 digits on account number panel on back of card. American Express: 4-digit code printed above account number on front of card)

Note: Any credit card refunds may be made by check.

I hereby authorize Delta Dental, its subsidiaries and affiliates to charge my credit card for the premiums due.

Cardholder Signature: Peter Heins Date: 09/18/2017

Paper Check

☐ Initial Payment ☐ Annual Billing

Check payments are allowed for initial payment or annual billing only. Please make check payable to Delta Dental of California and include name of primary enrollee in the memo field.

Automatic Recurring Payments (optional)

Sign below to activate automatic payments for future premium payments and policy renewals (only available for Direct Payment or Credit Card).

I hereby authorize Delta Dental to charge the applicable monthly premium for dental coverage to my account designated above. I understand that coverage will only become and remain effective if there are sufficient funds at the time of the deduction. I understand eligibility begins the first of the month following my initial deduction. This authority to deduct funds from my account is to remain in full force and effect until I notify Delta Dental in writing 30 days prior to termination. I also understand there cannot be any lapse of coverage in a 12-month period from the time of my enrollment. I agree to comply with the terms as outlined in the Disclosure Form/Policy. (My bank is authorized to make corrections if any should be necessary.)

Signature: Peter Heins Date: 09/18/2017

D. Authorization

☑ I understand that you must receive my initial payment by the 21st day of the month in order for my coverage to be effective on the first day of the following month.

☑ Go Paperless. I have read the Electronic Delivery Terms and Conditions (below) and I wish to receive my policy and all related policy documents electronically.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

Applicant Signature: Test App Date: 09/18/2017

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P.O. Box 1870, Alpharetta, GA 30023.

E. Agent/Producer Information

Applicable for Agent/Producer only

Name | Agent/Producer License Number

Delta Dental of California Agent/Producer Number

Email Address

Phone Number | Phone Number Type Mobile/Home/Business/Other

Signature | Date

F. Electronic Documents Terms and Conditions

1. **Communication Methods:** All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental website with your user name and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing."

   You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.

2. **Types of Documents that Will Be Electronically Communicated:** Documents available electronically include, but are not limited to: your application status, your dependent(s) application status, your billing statements, your payment method, your Policy and your claims information.

3. **Requesting Paper Copies:** You can obtain a paper copy of any electronic document by printing it yourself or by requesting that we mail you a paper copy. To request a paper copy, contact our Customer Service Center. There is no charge associated with requesting a paper copy of a communication we sent to you electronically.

4. **How to Withdraw Consent:** You may withdraw your consent to transact business electronically by indicating your preference at our website or by contacting our Customer Service Center without any charge. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.

5. **How to Update Your Records:** It is your responsibility to provide us with a true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information at our website or by contacting our Customer Service Center.

6. **Hardware and Software Requirements**: In order to access, view, sign and retain electronic documents that we make available to you, you must:

   - Have a device that will connect to the Internet, access to an email account and access to an Internet browser.
   - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.
   - Be able to view the disclosures on your device.
   - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.