Solutions INSURANCE
Health Insurance Specialists

Rohan Phillips

2015 S Ridge Dr
Coralville, IA 52241

128 2nd Ave SW
Cedar Rapids, IA 52402

P. 319 337 8871
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F. 888 530 7932

Delta Dental Application Process

1. Download and print the application form.
2. Complete the application in its entirety, answering all appropriate questions.
3. When application is complete, sign in the space provided.
4. Once all information has been completed, please return your application to the following address along with a check for the premium amount.
    a. Solutions Insurance, Rohan Phillips, 2015 S Ridge Dr, Coralville IA 52241
    b. Remember to include a voided check with your application
5. If you prefer, you can fax your application, along with a copy of a voided check to 888 530 7932

If you have questions at any time through this process, please call Rohan Phillips of Solutions Insurance to get the assistance you need.

Rohan Phillips will call you once the application is received to go over details of the application process.

Thank you for choosing to use Solutions Insurance as your Independent Agent. We are here to make sure that you get the best health insurance for your needs.

Sincerely

Rohan Phillips

DELTA DENTAL

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 1st of the month.*

Product Choice: ☐ Preventive ☐ Catastrophic ☐ Comprehensive	Social Security No.	Effective Date ______/__01__/_______
☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change		

SECTION I	Name (First, Middle Initial, Last)	Telephone ( )	Date of Birth ____/____/___	☐ Male ☐ Female
Complete Address – Street	City	State	Zip	Status: ☐ Single ☐ Married ☐ Other (specify)________________
E-mail address:		Please check the coverage you are applying for: ☐ Single ☐ Two-person ☐ Family		

SECTION II ELIGIBLE DEPENDENTS

List eligible members of your family to be covered First Name Middle Initial Last (if different)	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
Spouse		___/___/__	☐ M ☐ F		Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes
Dependent		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐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

Rohan Phillips / Benefit Solutions 7913453

Agent Name / Agency * NPN Insurance License #

Internal Use Only
Agency ID# ________

***This is the agency authorized by Delta Dental of Iowa to sell individual dental products.**

Agent0408

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.

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. Personal checks cannot be accepted as payment for this product.

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 60 days in advance of any rate adjustment.

Monthly Withdrawal Date: ❒ 1st of month ❒ 5th 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** (deposit slips are NOT acceptable for checking account information)
❒ Savings – please attach a pre-printed deposit slip and indicate:
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.**

____________________ ____________________________
Please Print Name of Insured Social Security Number of Insured

____________________ ____________________________
Signature of Payor Date Signed

Have you attached a voided personal check or a pre-printed personal savings account deposit slip from your financial institution?