DELTA DENTAL

Individual Dental Application/Update

Complete this form and mail or fax it to:

Norma Jean Rector
Blueprint Insurance Advisors
6135 Park South Drive, Suite 510
Charlotte, NC 28210
Fax: (704) 945-7104

If you have any questions about filling out this form, please contact our Customer Service department at (800) 971-4108.

☐ New Application — Check for first-time application for yourself or your Legal Spouse.
☐ 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 yourself or your Legal Spouse.

Will this policy replace or change any existing policy of dental insurance? ☐ Yes ☐ No
If yes, please describe: _____
Company Name _____ Policy Number _____

(This section must be completed for us to process your application or update your records. Please print clearly or type.)

Applicant Name *(First)* *(M.I.)* *(Last)*
_____ ____ _____
Birth Date(mm-dd-yyyy) Sex Applicant Social Security Number
_____ Male ☐ Female ☐ _____
Street Address
_____
City State Zip Code
_____ _____ _____
Email Address (Optional) Telephone Number
_____ _____
Coverage Effective Date
_____ **[(Access Code: Internal Use Only)]**
(date coverage takes effect for you and/or your Legal Spouse)

☐ Check here is this is a new address

Legal Spouse Information *(Please complete this section if you are enrolling your Legal Spouse for the first time or if you have checked Change/Correction above and are changing information about your Legal Spouse that was previously submitted. You must include your Legal Spouse's first and last names.)*

_____ ____ _____
Legal Spouse Name (*First*) *(M.I.)* *(Last)*
Birth Date Sex Social Security Number
_____ Male ☐ Female ☐ _____

Dependent Child Information
#1- Dependent Child Name *(First)* *(M.I.)* *(Last)*
_____ ____ _____
Birth Date Sex Social Security Number
_____ Male ☐ Female ☐ _____

Dependent Child Information
#2- Dependent Child Name *(First)* *(M.I.)* *(Last)*
_____ ____ _____
Birth Date Sex Social Security Number
_____ Male ☐ Female ☐ _____

Dependent Child Information
#3- Dependent Child Name *(First)* *(M.I.)* *(Last)*

_____ ____ _____

Birth Date Sex Social Security Number

_____ Male ☐ Female ☐ _____

Dependent Child Information
#4- Dependent Child Name *(First)* *(M.I.)* *(Last)*

_____ ____ _____

Birth Date Sex Social Security Number

_____ Male ☐ Female ☐ _____

Dependent Child Information
#5- Dependent Child Name *(First)* *(M.I.)* *(Last)*

_____ ____ _____

Birth Date Sex Social Security Number

_____ Male ☐ Female ☐ _____

Payment Information (The amount payable for coverage varies based on the coverage option selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling):

☐ Plan A
☐ Plan B
☐ Plan C

Payment Frequency:
☐ Annual (If you are paying by check, you must choose this option and pay the amount due in full)

☐ Monthly (If you are paying by credit card or automatic withdrawal, you may choose this option)

Choose the payment method:
☐ Check payable to Delta Dental **(you may pay by check only if you choose an annual payment)**
☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Card Number Exp. Date

_____ _____ _____

Cardholder Name *(as it appears on card)*

_____

Credit Card Billing Address *(if different from mailing address)*
Street Address

_____

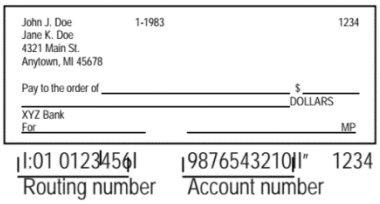
City State Zip Code

_____ _____

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for premiums 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
_____

Routing Number: Account Number:

☐ Checking Account _____ _____

☐ Savings Account

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 _____

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

_____

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (Please see the following page for state-specific variations of this fraud notice.)

Applicant's Signature _____ Date _____

Please mail enrollment form (and check, if applicable) to:

Agent Certification (if applicable): I hereby certify that I have truly and accurately recorded on this application, the information supplied by the Applicant. I further certify that I have been duly appointed by Delta Dental to solicit and negotiate and sell individual dental plans on its behalf.

Agent's Name (PRINTED) **Norma Jean Rector Access Code N057**

Agent's Signature _____ Date _____

Agent's Phone Number **704-945-7173**

Delta Dental of North Carolina
32399 Collection Center Drive
Chicago, IL 60693-0323