DELTA DENTAL

EUCLID MANAGERS

Application for Individual Dental Coverage

Please send completed application to:
Delta Dental of Illinois
P.O. Box 103
Stevens Point, WI 54481

Fax Number: 800-807-1970

PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL
Customer Service: 888-899-3736
www.deltadentalcoversme.com

Section 1 | Policyholder Information

Last Name	First Name	Middle Initial	Gender

Home Address (Mailing)	City	State	ZIP	Phone No. (with area code)

Email Address*	Date of Birth	Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Civil Union

**By providing my email address, I agree to receive communications regarding my Marketing, Policy and benefits electronically. For a full explanation of your rights, see* www.deltadentalcoversme.com/esignature-and-ueta-policies.

Requested Future Effective Date: ___/01/20___

Plan Selection

☐ Premium Plan* ☐ Delta Dental Individual Basic Plan ☐ Delta Dental Individual Preventive Plan
☐ Progressive Plan* ☐ Delta Dental Individual Kids Basic Plan
☐ Enhanced Plan* ☐ Delta Dental Individual Preferred Plan
☐ Base Plan* ☐ Delta Dental Individual Kids Preferred Plan

To learn more about plan designs visit www.deltadentalcoversme.com or call 888-899-3736.
These plan designs require that the policyholder be a covered person.

Employment Status: ☐ Employed ☐ Self-employed ☐ Retired ☐ Not currently working

Reason for Application: ☐ New Enrollment ☐ Change of Dependent(s)

Section 2 | Individuals to be covered

(Include YOURSELF if applying for coverage under plans that require the policyholder to be covered)

First Name	Last Name	Date of Birth	Relationship to Policyholder (Self, Spouse, or Dependent)	Gender	Disabled Child Y/N

PRIOR DENTAL INSURANCE COVERAGE. Were the above persons covered by a dental plan in the past 63 days?
☐ Yes ☐ No

Previous Carrier	Beginning Coverage Date	Ending Coverage Date

Policies issued in the State of Illinois are underwritten by:
Delta Dental of Illinois, NAIC #47589 111, Shuman Boulevard, Naperville, IL 60563.
All policies are administered, at least in part, by Delta Dental of Wisconsin and/or its subsidiary, Wyssta Services, Inc.

Section 3 | Payment Instructions - Required

To calculate rates please visit www.deltadentalcoversme.com or call 888-899-3736.

A debit, credit card or EFT (Electronic Funds Transfer) may be used to pay monthly, semi-annually or annually. If paying by check, remittance for the full annual 12 month premium is required, payable to Delta Dental.

Choose payment method: ☐ Debit/Credit Card ☐ Annual Check ☐ EFT

**Applications received on or after the 25th of the month must use a credit card if requesting a first of the following month effective date. If EFT payment is selected, your effective date will be adjusted to the first of the next month. Following the initial premium payment, your payment type can be updated at any time by logging in to www.deltadentalcoversme.com or by calling 888-899-3734.

Please complete the following information for payment by Debit/Credit Card:

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name:_____

Cardholder Address (if different than Policyholder):_____

City:_____ State: _____ ZIP Code:_____

Card Number:_____

Expiration Date: Month _____ Year _____ Security Code (from back of card): _____

Payment Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

Please complete the following information for payment by EFT:

Name of Financial Institution:_____

Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose One): ☐ Checking ☐ Savings Name on Account:_____

Bank Routing Number:_____ Bank Account Number:_____

Please attach a voided check to this application if you will be using your checking account for automatic payments.

I authorize Delta Dental to initiate debit entries from my above bank account or Debit/Credit card for my dental premiums.

Signature: _____ Date: _____

Your initial payment is due when the application is processed. Additional payments for upcoming periods will be deducted from your account on the month prior to its due date. If the charge is declined for any reason, we will attempt to charge you again the following month.

By signing below, I hereby authorize Delta Dental of Illinois to deduct the premium for my dental plan from the listed bank account or credit card on or about the 27th of each month for my monthly premium payment (if the payment method selected is monthly). I understand that the initial ACH debit or credit card charge to my account will occur immediately and if I have selected an annual payment option, the initial ACH debit or credit card charge will reflect the annual premium.

I agree that this authorization will remain in full force and effect until Delta Dental of Illinois has received written notification from me that I am terminating it.

I understand that Delta Dental of Illinois will notify me in advance of any changes to the premium amount. By signing below, I hereby authorize Delta Dental of Illinois and the bank or credit card company identified above to process the ACH debits or credit card charges authorized here.

If I am not the insured person under this policy, I confirm that I am agreeing to pay this insurance premium on behalf of the insured person. Unless the insured person is a minor for whom I am a parent or legal guardian, I understand that any changes to the policy that may affect the charge amount will be communicated to the insured person only.

I agree that if I have any problems or questions regarding this authorization or my insurance policy, I will contact Delta Dental of Illinois for assistance at 888-899-3734. I also agree that I will not dispute any charges with my bank or credit card company without first making good faith effort to resolve the dispute directly with Delta Dental of Illinois. I guarantee that I am the account holder for this bank account (for ACH debits) or legal card holder (for credit card charges) and that I am legally authorized to enter into this Recurring ACH Debit/Credit Card Billing Authorization Agreement with Delta Dental of Illinois

Additional Information if paying by ACH debit:
If my financial institution rejects an ACH debit from Delta Dental of Illinois due to insufficient funds, I understand and agree that Delta Dental of Illinois may in its discretion attempt to process the charge again within thirty (30) days. I understand that if my bank dishonors any ACH debit requested by Delta Dental of Illinois under this agreement, Delta Dental of Illinois may assess me a $25 service charge, and Delta Dental of Illinois may collect that service charge by means of an ACH debit. I also understand that Delta Dental of Illinois may apply that service charge each time it resubmits an ACH debit request that is rejected (even if it is for the same unpaid amount as a previously rejected ACH debit request).

Additional Information if paying with credit card:
I understand that any transaction that is dishonored by my credit card company intended for payment to Delta Dental of Illinois may be assessed a $25 service charge by Delta Dental of Illinois. Further, I authorize Delta Dental of Illinois to make any charges on a future policy I may purchase from Delta Dental of Illinois on the same credit card if I give verbal consent to Delta Dental of Illinois.

_____ _____

Policyholder Signature **Date**

Coverage is contingent upon underwriting acceptance

Agency Use Only	*Agency Name or Code:*		*Agent Name:*		*Agent #:*	

Policies issued in the State of Illinois are underwritten by:
Delta Dental of Illinois, NAIC #47589 111, Shuman Boulevard, Naperville, IL 60563.
All policies are administered, at least in part, by Delta Dental of Wisconsin and/or its subsidiary, Wyssta Services, Inc.

DeltaVision®

Application for Individual Vision Coverage

†DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

Please send completed application to:
ProTec Insurance Company
P.O. Box 103
Stevens Point, WI 54481
www.deltadentalcoversme.com

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BE SURE APPLICATION IS COMPLETED IN FULL
Customer Service: 888-899-3736
Fax Number: 800-807-1970

Section 1 | Policyholder Information

Last Name	First Name	Middle Initial	Gender

Home Address (Mailing)	City	State	ZIP	Phone No. (with area code)

Email Address*	Date of Birth	Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Civil Union

**By providing my email address, I agree to receive communications regarding my Marketing, Policy and benefits electronically. For a full explanation of your rights, see* www.deltadentalcoversme.com/esignature-and-ueta-policies.

Requested Future Effective Date: _/01/20___

DeltaVision® Plan Selection*†

☐ DeltaVision® Brilliance Plan ☐ DeltaVision® Essential Plan

To learn more about plan designs visit www.DeltaDentalCoversMe.com or call 888-899-3736.

Reason for Application: ☐ New Enrollment ☐ Change of Dependent(s)

Section 2 | Individuals to be covered

(Include YOURSELF if applying for coverage under plans that require the policyholder to be covered)

First Name	Last Name	Date of Birth	Relationship to Policyholder (Self, Spouse, or Dependent)	Gender	Disabled Child Y/N

Policies issued in the State of Illinois are underwritten by:
ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, 111 Shuman Boulevard, Naperville, IL 60563.
All policies are administered, at least in part, by Delta Dental of Wisconsin and/or its subsidiary, Wyssta Services, Inc.

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A debit, credit card or EFT (Electronic Funds Transfer) may be used to pay monthly, semi-annually or annually. If paying by check, remittance for the full annual 12 month premium is required, payable to ProTec Insurance Company.

Choose payment method: ☐ Debit/Credit Card ☐ Annual Check ☐ EFT

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Please complete the following information for payment by Debit/Credit Card:

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

CardholderName:_____

Cardholder Address (if different than Policyholder):_____

City:_____ State: _____ ZIP Code:_____

Card Number:_____

Expiration Date: Month _____ Year _____ Security Code (from back of card): _____

Payment Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

Please complete the following information for payment by EFT:

Name of Financial Institution:_____

Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose One): ☐ Checking ☐ Savings

Name on Account:_____

Bank Routing Number:_____ Bank Account Number:_____

Please attach a voided check to this application if you will be using your checking account for automatic payments.

I authorize ProTec Insurance Company to initiate debit entries from my above bank account or Debit/Credit card for my premiums.

Signature: _____ Date: _____

Your initial payment is due when the application is processed. Additional payments for upcoming periods will be deducted from your account on the month prior to its due date. If the charge is declined for any reason, we will attempt to charge you again the following month.

By signing below, I hereby authorize ProTec Insurance Company to deduct the premium for my dental plan from the listed bank account or credit card on or about the 27th of each month for my monthly premium payment (if the payment method selected is monthly). I understand that the initial ACH debit or credit card charge to my account will occur immediately and if I have selected an annual payment option, the initial ACH debit or credit card charge will reflect the annual premium.

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If I am not the insured person under this policy, I confirm that I am agreeing to pay this insurance premium on behalf of the insured person. Unless the insured person is a minor for whom I am a parent or legal guardian, I understand that any changes to the policy that may affect the charge amount will be communicated to the insured person only.

I agree that if I have any problems or questions regarding this authorization or my insurance policy, I will contact ProTec Insurance Company for assistance at 888-899-3734. I also agree that I will not dispute any charges with my bank or credit card company without first making good faith effort to resolve the dispute directly with ProTec Insurance Company. I guarantee that I am the account holder for this bank account (for ACH debits) or legal card holder (for credit card charges) and that I am legally authorized to enter into this Recurring ACH Debit/Credit Card Billing Authorization Agreement with ProTec Insurance Company

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Additional Information if paying with credit card:
I understand that any transaction that is dishonored by my credit card company intended for payment to ProTec Insurance Company may be assessed a $25 service charge by ProTec Insurance Company. Further, I authorize ProTec Insurance Company to make any charges on a future policy I may purchase from ProTec Insurance Company on the same credit card if I give verbal consent to ProTec Insurance Company.

_____ _____

Policyholder Signature **Date**

Coverage is contingent upon underwriting acceptance

Agency Use Only	*Agency Name or Code:*		*Agent Name:*		*Agent #:*	

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All policies are administered, at least in part, by Delta Dental of Wisconsin and/or its subsidiary, Wyssta Services, Inc.