# Enrolling is Simple.
# Just Follow These 3 Easy Steps…

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 877-566-5454 fax: 760-433-0304

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – annually

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

Barricks Insurance Services

276 N El Camino Real #6

Oceanside, CA 92058

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at: 877-566-5454**

**Thank you for choosing...**

DELTA DENTAL

# DeltaCare® USA

## DeltaCare USA INDIVIDUAL/FAMILY DENTAL PROGRAM CAA54
## ENROLLMENT AND PAYMENT AUTHORIZATION FORM

**Broker #:** 4378

**Delta Dental of California**
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703
(800) 422-4234

**Applicant/Dependent Information**

VERY IMPORTANT - PLEASE PRINT LEGIBLY
(To add additional dependents please attach a separate sheet)

Name: Last First MI

Mailing Address: Address

City State Zip

Date of Birth: Month Day Year ❑ Male ❑ Female Home Phone #

SSN/ID #: E-mail For internal use only

Contract Facility Name: Contract Facility #

I understand that, if I have indicated that coverage under the Program is to be provided only for the dependent child(ren) named on this form, I am responsible for payment of the required annual Premium and compliance with all of the provisions and conditions of the Disclosure Form/Contract.

I understand that I must select a DeltaCare USA Contract Dentist from the list of dental facilities. If the selected facility is not available, non-contracted or closed to further enrollment, Delta Dental reserves the right to assign me to another dental office as close as possible to my home. In the event that Delta Dental cannot assign me to a Contract Dentist my premium will be refunded.

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that Delta Dentalís ratio of health care expense to premiums received for the last calendar year, with respect to the DeltaCare USA Individual/Family Dental Program, was 67.91%.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

| Relationship Code* | Dependent Name | Male/ Female | Date of Birth |
|---|---|---|---|
| | | ❑ ❑ | |
| | | ❑ ❑ | |
| | | ❑ ❑ | |
| | | ❑ ❑ | |
| | | ❑ ❑ | |
| | | ❑ ❑ | |

* Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:

**Spouse - SP** **Domestic Partner - DP** **Child - CH** **Other Child - OC**

## PROGRAM COST AND PAYMENT OPTION (choose only one)

Check appropriate box based on the information below:

| | Plan CAA54 |
|---|---|
| ❑ Individual annual Premium | **$ 91.80** |
| ❑ Individual plus one dependent annual Premium | **$148.53** |
| ❑ Individual plus two or more dependents annual Premium | **$217.56** |
| One-time non refundable Enrollment Fee (required for new enrollment) | **$ 10.00** |
| **TOTAL** | **$_____** |

Indicate effective date: ___ ___ ___ (Month Day Year)

**This Enrollment and Payment Authorization Form and your check or money order, if applicable, must be received by the 21st day of the month for your coverage to be effective on the first day of the following month.**

I wish to enroll in the DeltaCare USA Individual/Family Dental Program. I acknowledge that I have read the Disclosure Form/Contract and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of Delta Dental, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Delta Dental provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

**PAYMENT OPTIONS**

❑ CHECK/MONEY ORDER PAYMENT OPTION
Please make check or money order payable to Delta Dental of California.

You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of coverage.

❑ CREDIT CARD PAYMENT OPTION

❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS

CARD # _____

EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CARD

_____

SIGNATURE _____

DATE _____

By signing above you authorize Delta Dental of California to charge your credit card account for the cost of the DeltaCare USA Program.

Note: Any credit card refunds under the Program may be made by check or credit card.

Signature: _____ Date _____

Return form to Delta Dental of California at P.O. Box 660138, Dallas, TX 75266-0138 or enroll online at www.deltadentalins.com

CAA54