



**Please send completed application to:**

Delta Dental of Wisconsin  
 P.O. Box 828  
 Stevens Point, WI 54481  
[www.deltadentalwi.com](http://www.deltadentalwi.com)

**Application for  
 Individual Dental Insurance**  
 PLEASE TYPE OR PRINT IN BLACK INK  
 BE SURE APPLICATION IS COMPLETED IN FULL  
 Customer Service: 888-899-3729

Last Name		First Name		Middle Initial	Gender: M/F
Home Address (Mailing)		City	State	ZIP	Phone No. (with area code)
E-mail Address			Date of Birth		Marital Status: Single/Married

Reason for Application:  New Enrollment  Change of Dependent(s)  Change in Enrollment (Single/Family Plan)

Select Plan: <input type="checkbox"/> Standard <input type="checkbox"/> Enhanced	Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family (Three or more persons)	<b>Monthly Rates:</b>	Standard Plan	Enhanced Plan
		Single	\$29.52	\$38.60
		Two-Person	\$58.73	\$77.03
		Family	\$99.93	\$134.33

If coverage under this policy is through membership in an association, please provide the name of the association:

**PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY**

First Name	Last Name (If different from Applicant)	Date of Birth	Relationship to Applicant	Gender M/F

**PRIOR DELTA DENTAL COVERAGE.** Were any of the above enrollees covered by a Delta Dental of Wisconsin employer-sponsored group plan within the past 60 days?  Yes  No

If yes, please provide the names of those enrollees:

_____	_____
_____	_____
_____	_____
_____	_____

Delta Dental of Wisconsin will verify previous coverage of enrollees. Upon validation, waiting periods may be waived.

**PAYMENT INSTRUCTIONS:**

A check can be submitted for the first payment on your policy. Thereafter, all premiums must be paid electronically using your checking/savings account or credit card.

Choose your payment method:  Check  Credit Card

**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.*

**Please complete the following information for payment by Credit Card:**

Card Type:  Visa  Mastercard  Discover  American Express

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ month \_\_\_\_\_ year Security Code: \_\_\_\_\_

I hereby authorize Delta Dental of Wisconsin, Inc. to initiate debit entries from my above bank account for my dental insurance premiums.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*I understand that any EFT transaction that is dishonored by my financial institution intended for payment to Delta Dental of Wisconsin, may be assessed a \$25.00 service charge by Delta Dental of Wisconsin.*

In making this application to Delta Dental of Wisconsin, Inc., (DDWI), for dental coverage under this program, I agree and understand that this application will become part of the Policy and I agree to be bound by the terms of the Policy issued by DDWI. I further agree that the coverage requested is subject to the approval of DDWI and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

By my submission of this application I attest that I am not eligible for dental coverage through Delta Dental of Wisconsin through my current employer. If at any time I become eligible for Delta Dental of Wisconsin group coverage through my employer, Delta Dental reserves the right to terminate this plan with thirty (30) days notice.

Your Policy will become effective on the first day of the month following approval of your application.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

*Coverage is contingent upon underwriting acceptance*

**FOR AGENT USE ONLY**

**Agency Code:** \_\_\_\_\_

**Agent Name:** \_\_\_\_\_

**Note to agents:**

*For commission to be paid accurately, it is vital that you enter the correct agency code assigned to you by Delta Dental of Wisconsin in the space indicated. If you are not sure of the agency code that has been assigned to you, contact your Delta Dental sales representative before submitting this application.*