Delta Dental Individual and Family
RENEWAL/CHANGE APPLICATION

If issued, your plan has a minimum commitment period. If you are accepted, your plan is issued by Delta Dental of Missouri (**doing business in the state of South Carolina as Delta Dental of South Carolina**). You are bound to have and maintain a minimum commitment period of **12 months** during the initial Membership Period and every 12 months thereafter with each successive renewal. In order to be eligible to enroll, the Applicant must be at least 18 years old and a resident of South Carolina. The effective date for coverage is always the 1st of the month and will be based upon Delta Dental's date of receipt and acceptance of this application. An application must be received by the 15th of the month prior to your policy effective date.

Please print clearly or type. Complete this form in full to ensure timely processing.

Reason for Form:	❑ Change of Coverage* ❑ Name/Address Change ❑ Change in Payment Information *If "Change of Coverage" is selected you may also need to complete Sections II & III below.

SECTION I

Applicant Name (First, Middle Initial, Last)	**Date of Birth** ___/___/___	❑ **Single** ❑ **Married**	❑ **Male** ❑ **Female**

Complete Address – Street	**City**	**State** SC	**Zip**

By providing my e-mail address below I agree to receive communications from Delta Dental electronically, including (Master Policy and Schedule of Benefits, welcome kit, and all notices from Delta Dental).

Social Security Number	**E-mail address**	**Telephone** ( )

Please select the coverage for which you are applying:

❑ Individual ❑ Individual & Spouse ❑ Individual & Children ❑ Family

SECTION II ELIGIBLE DEPENDENTS

List eligible members of your family to be covered (submit additional page, if necessary): Relationship	First Name	Middle Initial	Last Name	Social Security Number	**Date of Birth (mm/dd/yy)**	**Gender**
Dependent Spouse					___/___/___	❑ Male ❑ Female
Dependent Child					___/___/___	❑ Male ❑ Female
Dependent Child					___/___/___	❑ Male ❑ Female
Dependent Child					___/___/___	❑ Male ❑ Female
Dependent Child					___/___/___	❑ Male ❑ Female

SECTION III CHANGE OF COVERAGE (to be completed only if currently enrolled in the plan and requesting a change)

Please check the events requiring a change in coverage. Note: Eligibility changes as a result of a qualifying event must be reported within 31 days. ❑ Marriage ❑ Death ❑ Divorce ❑ Birth/Adoption ❑ Drop Dependent(s) ❑ Terminate Coverage

Name(s) of affected person(s): _____ Date of event: _____

SECTION IV PRODUCER INFORMATION (to be completed when requested by your agent, if any)

NOTE TO PRODUCER: Please contact Delta Dental first before processing enrollment for an Applicant. Delta Dental cannot assign commissions to this application without a BK number that will be assigned specifically to your business.

Producer Name	**Company Name**		
Address	**City**	**State**	**Zip**
License Number	**National Producer Number**	**Delta Dental Issued ID Number** BK:	
Taxpayer ID	**Email Address**	**Telephone** ( )	

Mail your application to Enrollment Services c/o Delta Dental, PO Box 22009, St. Louis, MO 63126 or FAX it to (314) 656-2875. *For questions about the processing of enrollment or the receipt of premium payment, please call Enrollment Services at (866) 991-7345 or e-mail* exchangeservices@deltadentalmo.com.

Your application must be executed in Section VI (and Section VII, if applicable) on the next page in order to process.

SECTION V PAYMENT OPTIONS

By signing this application, you agree to pay premiums by (select only one box below):

- ❑ Check – one payment for 12 months of premiums. This option includes a 2% discount. NOTE: Your application will be denied if the check is not written for the full 12 months of premiums. Delta Dental will not accept corporate checks.
- ❑ Automatic debit – monthly withdrawal from my bank account (ACH transaction) on the 19th of the month.
- ❑ Automatic debit – one payment for 12 months of premiums (ACH transaction). This option includes a 2% discount.
- ❑ Debit/Credit Card – one payment for 12 months of premiums. This option includes a 2% discount.
- ❑ Debit/Credit Card – monthly payment automatically applied to my credit card on the 19th of the month.
- ❑ Money Order - one payment for 12 months of premiums. This option includes a 2% discount.

BY CHECK or Money Order- If you elect to pay by check or Money Order, please make it payable to Delta Dental of Missouri, and mail, along with your application, to Enrollment Services c/o Delta Dental, PO Box 22009, St. Louis, MO 63126. Note: Your application will not be complete until we have received your check or Money Order payment.

BY AUTOMATIC DEBIT - If you elect to pay by automatic debit, you must complete Section VI below and include a copy of a voided check or deposit slip to validate your account and routing number. An ACH can only be withdrawn from the account of the Applicant.

By electing to pay by automatic debit, I authorize Delta Dental of Missouri and its representatives to initiate electronic debit entries (and corrections to previous debits) to my checking or savings account indicated below for amounts due to Delta Dental and I authorize the financial institution named below to debit these entries from my account. This authority remains in effect until I revoke it by giving Delta Dental at least 31 days prior written notice of such revocation. I agree that Delta Dental and my financial institution shall be fully protected in honoring any such debit. I understand that premium rates and other charges are subject to change by Delta Dental giving at least 31 days prior written notice of any change. I understand that if my withdrawal is not honored by my financial institution, Delta Dental may remove me from the automatic debit payment program, in which case, I must pay by check.

Date of Debit – 19th of Each Month – This product is a pre-paid dental benefits plan. If you have elected to make payments on a monthly basis, these payments are required by the 19th of each month for your next month of coverage. When first enrolling, the premium payment for your first month of coverage will be withdrawn immediately. For example, if we receive and accept your enrollment application on 1/15, your February premiums will be withdrawn on the processing date. The March premiums will be withdrawn on February 19th. For months other than your initial premium month, your account will be debited on the 19th of the month for the next month's premiums. If the 19th falls on a weekend or bank holiday, the withdrawal will occur on the following business day. If paying annually, the annual premium will be withdrawn during the initial enrollment process.

BY DEBIT OR CREDIT CARD – If you elect to pay by debit or credit card, please complete Section VII.

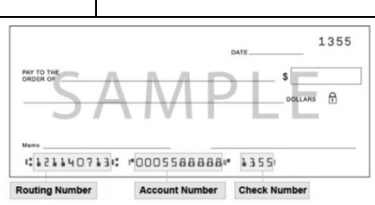
SECTION VI BANKING INFORMATION – Must be completed in the name of the Applicant only

Banking Information: ❑ Initial Information ❑ Change in Information

Account Holder Name **Must be the Applicant's account.*	Financial Institution	Branch (if applicable)
Address	City	State / Zip
Account Type ❑ Checking ❑ Savings	Routing Number (9 digits)	Account Number

This authority is to remain in full force and effect until Delta Dental of Missouri has received at least 31 days prior written notice from the Applicant of its termination.

Print Name of the Applicant	SSN of Applicant
SIGN HERE - Signature of Applicant	Date



SECTION VII DEBIT/CREDIT CARD INFORMATION – Must be completed in the name of the Applicant only

Card Information: ❑ Initial Information ❑ Change in Information

Card Holder Name as it appears on the card. **Must be the Applicant's account.*	Card Type: ❑ Debit Card ❑ VISA ❑ MasterCard ❑ Discover ❑ American Express	Card # (16 digits)
Expiration Date	3 or 4 digit authorization code (found on back of card)	

Print Name of the Applicant	SSN of Applicant
SIGN HERE - Signature of Applicant	Date

This authority is to remain in full force and effect until Delta Dental of Missouri has received at least 31 days prior written notice from the Applicant of its termination. Applicant represents he or she is the authorized cardholder of this account and gives Delta Dental of Missouri the authority to apply the applicable monthly premiums due to this account and Applicant agrees to pay such amount.

SECTION VIII APPLICATION AGREEMENT AND AUTHORIZATION

By signing this application, you (and your spouse, if the spouse is to be covered) acknowledge, agree, represent and authorize, as applicable, each of the following.

I represent that I am at least 18 years old and a resident of South Carolina and legally authorized to apply for coverage for myself and all other persons named in this application. I acknowledge my understanding that I am applying for individual coverage offered by Delta Dental of Missouri and agree to a minimum commitment period of 12 months during the initial Membership Period and every 12 months thereafter with each successive renewal. I agree to pay all monthly premiums due to Delta Dental for this coverage in a timely manner for each commitment period, including even if I elect to discontinue coverage before such minimum commitment period has been satisfied. If payment is not made when due, I acknowledge that my coverage may be terminated by Delta Dental. I acknowledge that if this coverage is terminated, either voluntarily or involuntarily, neither I nor any person named in this application is eligible to apply for individual coverage offered by Delta Dental for a period of 12 months from the date of termination. I acknowledge that coverage under this plan will not commence until after this application and the required premiums are received and accepted by Delta Dental and then only on the effective date established by Delta Dental for such coverage. If accepted for coverage, I agree to comply with the terms, conditions and restrictions of the Master Policy and Schedule of Benefits, including, without limitation, the obligation to notify Delta Dental of any change that would make me or any dependent ineligible for coverage. I agree that any notice required or permitted to be given by Delta Dental under the Master Policy and Schedule of Benefits is sufficient if it is mailed or given by electronic means to me at the address appearing on Delta Dental's records for me. Without limiting the foregoing, I agree that Delta Dental may issue the Master Policy and Schedule of Benefits (and amendments thereto, including notices of such amendments) by electronic means to me.

I represent that the statements, information and answers set forth in this application are true, complete 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 acknowledge that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made. Any false statement, misrepresentation or omission of any material fact found in this application may result in a denial of benefits or rescission or cancellation of my coverage.

I authorize any health care provider to release medical records to Delta Dental when reasonably related to the dental care coverage for which I have applied. I give this authorization for and on behalf of myself and any person named herein; I am acting as their agent and representative. If an additional authorization is required and I fail to give it, I acknowledge that such failure may result in a denial of benefits.

I acknowledge that initial placement of full or partial removable dentures, fixed bridges (including crowns which form a part thereof) to replace a tooth or teeth that were missing prior to the Participant's Membership Effective Date will not be covered unless the prosthetic appliance also includes replacement of a natural tooth or teeth extracted while this coverage was in effect.

If my payment is not honored, I authorize Delta Dental or its representative to make additional attempts to collect payment using the authorized payment method.

I acknowledge that I have the right to withdraw my consent to receive electronic communications and can elect to receive paper notices from Delta Dental by contacting Delta Dental using the contact information contained on the front page of this application.

SIGN HERE - You and your spouse (if the spouse is to be covered) must sign below. By signing below, you each acknowledge that you have read and understand this application, and accept and agree to be bound by all of the provisions of this application.

_____	_____	____ / ____ / ____
Applicant Printed Name	Applicant Signature	Date
_____	_____	____ / ____ / ____
Spouse Printed Name	Spouse Signature	Date

Reminder: Please be sure to remit a voided check if you choose to pay by ACH from the Applicant's checking account.