DELTA DENTAL®

MAIL TO: H&H Benefits Specialists
1301 West 7th Street
Little Rock, AR 72201

REQUESTED EFFECTIVE DATE		
MONTH	DAY	YEAR
	1st	

Individual & Family Application | Plan number SOARR01

Rates effective: October 1, 2019 — December 31, 2022

APPLICANT INFORMATION			
Name:	Date of Birth:	☐ Male ☐ Female	
Mailing Address:	City:	State:	ZIP:
Social Security #:	Home Number:		
Email:	Mobile Number:		

PLAN SELECTION (CHOOSE ONE)

☐ Dental ☐ Dental and Vision

TYPE OF COVERAGE (CHOOSE ONE)

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual and Family

DEPENDENTS

	First Name	Last Name	Social Security #	Date of Birth	Sex
Spouse					
Child					
Child					
Child					

PREVIOUS COVERAGE

Will this replace existing dental coverage? ☐ YES ☐ NO	If you are purchasing this coverage to replace an existing Delta Dental of Arkansas plan, please provide the anticipated termination date of your current plan:_____ If the coverage will replace a plan with another carrier, please submit a copy of the Certificate of Creditable Coverage and a list of covered benefits. A Certificate of Creditable Coverage benefits can be obtained from your previous insurance carrier on your employer group health administrator.

HOUSEHOLD RESIDENTIAL INFORMATION

Do all proposed insured reside in Arkansas? ☐ YES ☐ NO | If no, provide reason:

PAYMENT METHOD - BANK DRAFT OR CREDIT CARD ONLY (DO NOT SEND A LIVE CHECK)

Bank Draft: ☐ Monthly ☐ Annually
Bank Account: ☐ Checking ☐ Savings

Routing Number:_____
Account Number:_____

Include a voided check with application.

I authorize Delta Dental of Arkansas (DDAR) and the BANK* indicated above to debit my DDAR premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such a time and such a manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) day written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorization Bank Draft Program after I have agreed to it, I will also be terminating my DDAR coverage, unless DDAR has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorization Bank Draft Program date.

_____ _____
Signature of Bank Account Holder Date

Monthly bank drafts are processed on the 5th of each month. *BANK also applies to Savings and Loan.

WHY DENTAL INSURANCE?

People with dental insurance typically visit the dentist more often than those without, resulting in better dental and overall health.

Besides keeping your smile healthy, your dentist can also help identify more than 120 signs and symptoms of non-dental diseases —including heart disease and diabetes—before they become larger problems.[1]

Prevention costs less than treatment. Most dental plans, such as Delta Dental Individual and Family, encourage prevention by covering the cost of exams, cleanings, X-rays and more in order to help prevent dental disease rather than to perform expensive, and sometimes painful, restoration work later.

DENTAL PLANS	Delta Dental Dentist	Non-participating Dentist
Individual/family deductible	$50/$150	
Individual benefit-year maximum	$1,500	
What the plan pays for after you have satisfied the deductible		
Preventive & Diagnostic	100%	80%
Basic Restorative Services	80%	60%
Major Restorative Services	60%	50%
Waiting Periods*		
Preventive & Diagnostic	None	
Basic Restorative Services	None	
Major Restorative Services	6 Months	

Monthly Premiums	
Individual Only	$38.98
Individual & Spouse	$77.70
Individual & Child(ren)	$75.86
Individual & Family	$125.72

The dental plans offered in this brochure do not include pediatric dental services as required under the Affordable Care Act (ACA). To learn about Delta Dental's ACA compliant dental plans and assistance to determine if you need an ACA compliant pediatric dental plan, call our marketing representatives at (800) 971-4108 or visit www.mysmilecoverage.com/AR.

*Deductible does not apply.

OUT-OF-NETWORK BENEFITS (NON-PARTICIPATING)

Services conducted through an out-of-network dentist will be reduced as indicated above by Delta Dental of Arkansas after applying the applicable deductibles, copayments and maximums. This means your out-of-pocket expense will be more if you choose an out-of-network dentist.

*WAITING PERIODS WILL BE WAIVED IF:

1. Your application is received within 31 days of the termination of your prior carrier.
2. You have had at least six months of continuous coverage in Major Restorative Services.

To waive waiting periods, please submit a copy of your Certificate of Creditable Coverage verifying your previous dental coverage and a copy of your covered benefits.

Delta Dental has the largest network of dentists in Arkansas and across the nation,[2] which means you will find affordable care wherever you are.

1 J Am Dent Assoc, Vol 134, No suppl_1, 41S-48S. 2003 American Dental Association and Dental Management of The Medically Compromised Patient, 8th Edition, 2013, Mosby Elsevier, St. Louis, MO. 2 Delta Dental Plans Association, web.