DELTA DENTAL®

MAIL TO: Arkansas Health First
1301 West 7th Street
Little Rock, AR 72201
FAX: (501) 663-1445
Email: service@arseba.com

REQUESTED EFFECTIVE DATE		
MONTH	DAY	YEAR
	1st	

Individual & Family Application | Plan number SOARR01

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

PLAN SELECTION (CHOOSE ONE)	TYPE OF COVERAGE (CHOOSE ONE)
☐ Dental ☐ Dental and Vision	☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ 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

Previous Coverage Carrier: _____ Previous Policy #_____
Previous Coverage Start Date: _____ End Date: _____

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 so we can determine if waiting periods for your Delta Dental plan can be waived. 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 insureds 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 27th of each month. *BANK also applies to Savings and Loan.

CREDIT CARD INFORMATION

Credit Card: ☐ Monthly ☐ Annually **Credit Card Type:** ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number:_____ Expiration Date (MM/YYYY):_____

Credit Card Holder's Name: _____

CVC Number (3 digit security code on back of card):_____

_____ _____

Signature of Credit Card Holder Date

Your first premium payment will be processed when your application is submitted. Subsequent drafts are processed on the 27th of each month. (Example: February premium will be drafted on January 27th.)

CORRESPONDENCE

NOTICE: All correspondence regarding this plan will be sent electronically to the email address listed on the front of this application unless applicant requests to be contacted via mail.	☐ Opt OUT of electronic correspondence

POLICY EFFECTIVE DATE

The Delta Dental policy effective date is always the 1st of the month. Applications can be submitted through mail or online at www.deltadentalcoversmysmile.com/s/SOAR. This application must be received by Delta Dental of Arkansas by the 25th of the month prior to the effective date (example: received by January 25th to be effective February 1st). Applications received after the 25th of the month will be made effective on the 1st of the following month (example: received January 26th, will be effective March 1st).

AUTHORIZATION

I authorize dentists, dental office personnel and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

Applicant's Signature: _____ Date:_____

Signature of Parent/Legal Guardian: _____ Date:_____

(if policy is for a minor only)

City in which application was signed:_____, Arkansas

CERTIFICATION

I understand that I will not have benefits for basic and major restorative services (depending on my selected plan) during the first 6 months after the issue date, including for a disease or physical condition which I now have or have had in the past, unless I supply Delta Dental of Arkansas with certification of creditable coverage.

I certify that any information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fine and confinement in prison. Statements made in this application are representations not warranties.

_____ _____

Applicant Signature Date

To be completed by sales representative ONLY if applicable

Agent's Name: _____ Agency's Name: Arkansas Health First

Agency NPN#: 19299106 Telephone Number: (888) 224-5233