DELTA DENTAL®

RETIREE CONVERSION ENROLLMENT FORM

Delta Dental of Oklahoma | PPO – Point of Service Plan

Retiree Information

Name		**Date of Retirement**
Mailing Address		**Date of Birth**
City	**State**	**Zip**
Social Security Number	**Email**	
Home Phone Number	**Mobile Phone Number**	

Plan Selection and Dependent Enrollment

Plan Type (select one): Retiree Retiree + 1 (spouse or one child) Retiree + Family

List all dependents to be enrolled (complete for spouse and/or all dependent children under 23 years of age)

Spouse Name	**Date of Birth**
Dependent Child Name	**Date of Birth**
Dependent Child Name	**Date of Birth**
Dependent Child Name	**Date of Birth**
Dependent Child Name	**Date of Birth**

Billing and Payment

Automatic Draft† Options (select one): Monthly* | Annual**

Financial Institution	**Branch**
Account Number	**Bank Routing Number**

Type of Account (select one): Checking Savings

†To set up automatic draft, **a voided check must be attached to this enrollment form in the space provided on the next page.**

*Initial premium will be drafted from your account immediately upon approval of this application. Subsequent drafts will be made on the fifth (5th) of each month and applied to that month's premium.

**Initial premium will be drafted from your account immediately upon approval of this application. Subsequent annual drafts will be made on December 20th each year and applied to the next year's premium.

Termination Requirement: Please note that you must provide a minimum of 30 days written notice to Delta Dental of Oklahoma prior to requested termination date.

ATTACH VOIDED CHECK HERE

Acknowledgement, Authorization and Signature

Warning: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Acknowledgement and Authorization: By clicking the submit button, I agree to continue coverage as provided in the Individual Policy issued by Delta Dental of Oklahoma and acknowledge I have read the Privacy Policy. To cover the cost of my dental benefits for which I have made request, and for which I am or may become insured, I hereby authorize Delta Dental to draft my designated account until further notice. I understand and agree that failure to make funds available in sufficient amounts to cover the cost of my dental benefits for which I have made request shall result in the termination of my coverage effective on the paid-through date reflected in DDOK records at the time of such failure. I understand my Individual Dental Policy and all communications and notices (renewal, delinquency, and/or termination) shall be provided electronically, and hereby consent to such delivery/administration. Further, I understand my consent to the electronic delivery/administration may be declined initially, or may be rescinded in the future by providing Delta Dental of Oklahoma with written notice of intent to rescind such consent at least 30 days prior to the rescission effective date. I further understand and agree that declining consent to electronic delivery/administration of my Individual Dental Policy and benefits thereunder initially, or future rescission of such consent, shall result in a paper delivery/administration fee in the amount of $15.00 per month, which shall be added to the monthly automatic draft of my designated personal bank account or payable by personal check or money order if paying annual premium in full.

By checking this box as the enrollee, you confirm explicit consent regarding Delta Dental of Oklahoma's collection, use, disclosure, maintenance, storage and disposal of Customer Protected Health Information and Personally Identifiable Information as described in the enrollment form's Privacy Policy online at DeltaDentalOK.org/PrivacyPolicyIndividual, or by mail upon request, and Delta Dental of Oklahoma's Notice of Privacy Practices available at DeltaDentalOK.org/HIPAANoticeIndividual, or by mail upon request.

Retiree's Signature: _____ **Date:** _____

Submission Information

Email to: INDY@DeltaDentalOK.org

Mail to: Delta Dental of Oklahoma
Attn: Individual and Family Services
PO Box 54709
Oklahoma City, OK 73154

Broker/Agent Code (five or six digits)
