# INDIVIDUAL AND FAMILY CHANGE FORM

**Delta Dental of Oklahoma**

## Primary Subscriber Information

**Last Name** **First Name** **Middle Initial**

**Social Security Number** **Date of Birth** (MM/DD/YYYY)

## Plan Change Request

**Reason for Change** (select one): ☐ Change of Dependent(s) ☐ Change of Plan ☐ Change of Payment Frequency

**Requested Future Effective Date** (MM/DD/YYYY)

**Frequency** (select one): ☐ Monthly ☐ Annual

**Plan Selection** (select one):

Change requests received on or after the 19th of the month will be processed for the first (1st) of the next month's effective date. For example, a change request submitted on or before April 18 will be processed for May 1. Earliest possible effective date for change forms submitted on April 19 would be June 1.

| 2024 MONTHLY PREMIUM | ☐ Delta Dental PPO | ☐ Delta Dental PPO – Point of Service |
|---|---|---|
| Individual: | $38.00 | $63.00 |
| Individual + Spouse: | $76.00 | $126.00 |
| Individual + Child(ren): | $88.00 | $166.00 |
| Family: | $130.00 | $237.00 |

***Additional information regarding plan designs is available at DeltaDentalOK.org/CoversMe***

**Plan Type** (select one): ☐ Individual ☐ Individual + Spouse ☐ Individual + Child(ren) ☐ Family

## Dependent Information

List all dependents to be enrolled (complete for spouse and/or all dependent children under 26 years of age).

**Spouse First and Last Name** **Date of Birth** (MM/DD/YYYY)

**Dependent Child First and Last Name** **Date of Birth** (MM/DD/YYYY)

**Dependent Child First and Last Name** **Date of Birth** (MM/DD/YYYY)

*If your plan needs to cover more dependents, please proceed entering as many dependents as this change form will allow. Upon completion, please submit your enrollment to Indy@DeltaDentalOK.org with the names and dates of birth of the additional dependents to add to your plan.*

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. **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. I understand my Individual Dental Policy and all communications and notices (renewal, delinquent and/or termination) regarding my policy and benefits will be delivered/administered electronically and hereby consent to such electronic delivery/administration. I understand that such consent to 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. Further, I acknowledge that failure to consent initially to electronic delivery/administration of the Select group dental plan, or future rescission of consent shall result in a $15.00 monthly paper delivery/administration fee, 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/HIPAANotice, or by mail upon request.

**Applicant Signature:** _____ **Date:** _____

## Submission Information

**Email to:** Indy@DeltaDentalOK.org

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