INDIVIDUAL AND FAMILY TERMINATION FORM

Delta Dental of Oklahoma

Primary Subscriber Information

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

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

Please provide the following information so DDOK may process your individual and family termination in a timely manner.

Reason for Termination (select one):

- Moved Out of State
- Premium Rates/Cost
- Benefits/Claims Processing
- Participating Provider Network
- DDOK Service
- __ Deceased
- Covered by another DDOK plan
- __ Covered by _____ Carrier's plan

Requested Future Termination Date (MM/DD/YYYY):_____

NOTE: Termination requests received on or after the 19th of the month will be processed for the end of the following month, unless insufficient premium payment and/or plan utilization requires the date to be modified. For example, a termination request submitted on or before April 18 will be processed for May 1. Earliest possible termination date for requests submitted on or after April 19 would be June 1.

As the Policyholder for the above listed Individual and Family plan, I hereby authorize termination of my dental benefits plan for the requested termination date. I understand and agree that failure to make funds available in sufficient amounts to cover the remaining cost of my dental benefits 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 regarding my policy and benefits, including but not limited to renewal, delinquent, and termination correspondence, will be delivered/administered electronically and by signing this form, I agree to such electronic delivery/administration unless I decline such electronic delivery/administration initially in writing. Further, I understand my consent to the electronic delivery/administration of my policy, communications, and notices can be rescinded in the future by providing DDOK with written notice of intent to rescind such consent at least 30 days prior to the rescission effective date.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 electronic delivery/administration 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.

Be advised: 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.

Delta Dental of Oklahoma's collection, use, disclosure, maintenance, storage and disposal of Customer Protected Health Information and Personally Identifiable Information is described in the Privacy Policy available 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.

Subscriber Signature **Date** (MM/DD/YYYY)

Submission Information

Email to: Indy@DeltaDentalOK.org

Fax to: 405-607-2157

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