Delta Dental Patient Direct® Application

PART A – Enrollment

First Time Enrollment ☐ Re-Enrollment ☐

☐ Enrollee $123 (Annual Fee $98 + Enrollment Fee $25)	☐ Age 60+ Enrollee $113 (Annual Fee $88 + Enrollment Fee $25)	☐ Enrollee $98 (Enrollees 60 + $88)
☐ Enrollee + 1 Dependent $150 (Annual Fee $125 + Enrollment Fee $25)	☐ Age 60+ Enrollee + 1 Dependent $137 (Annual Fee $112 + Enrollment Fee $25)	☐ Enrollee + 1 Dependent $125 (Enrollees 60 + $112)
☐ Enrollee + Family $199 (Annual Fee $174 + Enrollment Fee $25)	☐ Age 60+ Enrollee + Family $183 (Annual Fee $158 + Enrollment Fee $25)	☐ Enrollee + Family $174 (Enrollees 60 + $158)

Please include a check for the applicable amount shown above. Please make the check payable to Delta Dental of New Mexico.

Were you referred by an Insurance Agent? ☐ No ☐ Yes If yes, please provide the Agent's name: _____

PART B – Applicant Information (ALL FIELDS ARE REQUIRED)

Applicant name *(last, first, middle initial)*	Gender ☐M ☐F	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth __ __/__ __/__ __ __ __
Home mailing address	Apt#	City	State Zip
Home Phone: ( ) -	Mobile Phone: ( ) -		

PART C – Dependent Information – For Dependents to be Enrolled *(For additional dependents, use a separate sheet and attach.)*

Spouse *(last, first, middle initial)*	Gender ☐M ☐F	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth __ __/__ __/__ __ __ __
	Relationship		
Dependent to be enrolled *(last, first, middle initial)*	Gender ☐M ☐F	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth __ __/__ __/__ __ __ __
	Relationship		
Dependent to be enrolled *(last, first, middle initial)*	Gender ☐M ☐F	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth __ __/__ __/__ __ __ __
	Relationship		
Dependent to be enrolled *(last, first, middle initial)*	Gender ☐M ☐F	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth __ __/__ __/__ __ __ __
	Relationship		

PART D – Terms and Conditions

I have read the information available in the Delta Dental Patient Direct brochure. In addition to the information provided therein, I understand that:

1. Delta Dental Patient Direct is a discount dental program, not insurance, which entitles me to discounts only from New Mexico participating dentists;
2. Participating dentists, who are not employees of Delta Dental, independently elect to participate in Delta Dental Patient Direct and may join or decline participation in the network at any time;
3. Delta Dental of New Mexico makes no guarantees as to the size or scope of the Delta Dental Patient Direct provider network that will be available at the time dental care services are required;
4. If, for any reason, I am not completely satisfied with Delta Dental Patient Direct I may request a full refund of my initial and annual enrollment fee. Delta Dental Patient Direct ID cards must be returned to Delta Dental of New Mexico with a written request for the refund postmarked within 45 days of the date the Delta Dental Patient Direct ID cards were mailed to me.
5. Refund entitlement applies only to individuals enrolling in Delta Dental Patient Direct for the first time;
6. Refunds, and the termination of eligibility for Delta Dental Patient Direct discounts, apply to the primary adult enrollee and each individual enrolled with the primary adult enrollee;
7. Patients are responsible for all communications with their dentists related to appointments and services, and for all payments for dental care services received.

Applicant Signature _____ Date Signed _____