



Individual Dental Plan Enrollment/Update

Enroll online now at www.mysmilecoverage.com/nm or complete this form and mail it to:

Delta Dental Use Only:
For plan #87110

Delta Dental of New Mexico
Individual Product Unit
P.O. Box 1596
Indianapolis, IN 46206

For help filling out this form, please contact the Individual Product Unit at (800) 971-4108.

- New Enrollment:** Check for first-time enrollment.
- Change/Correction to Information:** Check if any changes are being submitted on this form.
- Termination of Benefits:** Check only if you are terminating coverage for you and/or your dependents.

This type of plan is NOT considered “minimum essential coverage” under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

Will this Policy replace or change an existing policy of dental insurance? * Yes No
If yes, please describe:

*Delta Dental may choose to waive applicable Benefit waiting periods if you had recent fully insured dental coverage. Please contact the Individual Product Unit at (800) 971-4108 for more information.

Part A – Insured’s Information

Insured’s Name (First, Middle Initial, Last)		E-mail Address (Optional)
Date of Birth (MM/DD/YYYY) ____/____/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number ____-____-_____
Street Address (Including City, State, ZIP Code)		<input type="checkbox"/> Check here if new address
Telephone Number ____-____-_____	Coverage Effective Date** (MM/DD/YYYY) ____/____/_____	

**The date coverage takes effect for you and/or your dependents. This date must be on the first day of a month, and may be as early as the first day of the month following the month in which your application is approved.

Part B – Spouse or Domestic Partner’s Information

Spouse or Domestic Partner’s Name (First, Middle Initial, Last)		
Date of Birth (MM/DD/YYYY) ____/____/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number ____-____-_____

Part C – Dependent Child Information

#1 – Dependent Child’s Name (First, Middle Initial, Last)		
Date of Birth (MM/DD/YYYY) ____/____/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number ____-____-_____

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#2 - Dependent Child's Name (First, Middle Initial, Last)		
Date of Birth (MM/DD/YYYY) ____/____/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number ____-____-_____
#3 - Dependent Child's Name (First, Middle Initial, Last)		
Date of Birth (MM/DD/YYYY) ____/____/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number ____-____-_____
#4 - Dependent Child's Name (First, Middle Initial, Last)		
Date of Birth (MM/DD/YYYY) ____/____/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number ____-____-_____
#5 - Dependent Child's Name (First, Middle Initial, Last)		
Date of Birth (MM/DD/YYYY) ____/____/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number ____-____-_____

Part D - Plan Selection and Rates

The amount payable for coverage varies based on the coverage option selected, the age of the Enrollee, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling.

Delta Dental Individual - Core Plan - Delta Dental PPOSM Network

Age Bracket	Single Rate (Monthly/Annual)	Two-Person Rate (Monthly/Annual)	Family Rate (Monthly/Annual)
Age 54 and under:	\$23.25/\$279.00	\$44.63/\$535.56	\$76.48/\$917.76
Age 55 and over:	\$27.80/\$333.60	\$55.60/\$667.20	Multiple of Single Rate.

Delta Dental Individual - Enhanced Plan - Delta Dental PPO Point of Service Network

Age Bracket	Single Rate (Monthly/Annual)	Two-Person Rate (Monthly/Annual)	Family Rate (Monthly/Annual)
Age 54 and under:	\$33.21/\$398.52	\$63.77/\$765.24	\$109.27/\$1,311.24
Age 55 and over:	\$40.26/\$483.12	\$80.52/\$966.24	Multiple of Single Rate.

Part E - Payment Frequency and Method

Payment Frequency

- Annual** (Payable by check, credit card, and automatic withdrawal. If you are paying by check, you **must** choose this option.)
- Monthly** (Payable by credit card and automatic withdrawal.)

- Check payable to Delta Dental of New Mexico** (You may pay by check only if you choose an annual payment.)



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Credit Card Payment (Choose One): MasterCard VISA Discover

Card Number

Expiration Date (MM/YYYY)

Cardholder's Name (As It Appears On Card)

CVV Code (Last Three Digits on the Back of Your Credit Card)

Credit Card Billing Address (If Different from Mailing Address - Including Street Address, City, State, ZIP Code)

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for Premium due. This authorization will remain in effect until Delta Dental has received written notice from me of its termination. If the billing amount changes, Delta Dental will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature _____ Date _____

Automatic withdrawal from bank account

Bank Name

Account Type

Checking Savings

Routing Number

Account Number

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature _____ Date _____

Part F - Validation Question, and Signature

Validation Question (Choose ONE and Answer Below)

Mother's maiden name (last name only) OR City in which you were born OR Name of first pet

Answer to Validation Question

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 civil fines and criminal penalties.

Applicant's Signature _____ Date _____

Please mail enrollment form (and check, if applicable) to:

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