



Individual Choice - Premier Enrollment/Update

PLAN TYPE: FAMILY INDIVIDUAL

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS, EXPLANATION OF CODES, AND PRIVACY POLICY STATEMENT.

Delta Dental of Oklahoma
P.O. Box 54709
Oklahoma City, OK 73154

Fax to:
405-607-2157
Attn: Client Services

BROKER/AGENT CODE
A S 2 0 0 5

GROUP# **4 9 0 3** - SUBGROUP#

Policyholder Information: (please complete in ink)

POLICYHOLDER NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARTIAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S
POLICYHOLDER SOCIAL SECURITY #		BIRTH DATE	TODAY'S DATE	COVERAGE EFFECTIVE DATE		
ADDRESS					PHONE	
CITY			STATE	ZIP	CHECK HERE IF THIS IS A NEW ADDRESS <input type="checkbox"/>	
E-MAIL ADDRESS						

Payment Election: ACCT. NAME: _____ **BANK NAME:** _____

BANK ROUTING NO. _____ MONTHLY DRAFT BY DDOK, ACCOUNT NO. _____

ANNUAL PAYMENT IN FULL BY CHECK ANNUAL PYMT IN FULL BY DDOK DRAFT, ACCOUNT NO. _____

Enrollment/Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: ____/____/____

TERMINATION REQUIREMENT:

PLEASE NOTE THAT YOU MUST PROVIDE A MINIMUM OF 30 DAYS WRITTEN NOTICE TO DELTA DENTAL OF OKLAHOMA.

CHANGE IN CURRENT ELIGIBILITY STATUS FOR: POLICYHOLDER DEPENDENTS
 REASON FOR CHANGE: DIVORCE MARRIAGE NAME CHANGE ADOPTION/LEGAL GUARDIANSHIP*
 OTHER _____

* LEGAL DOCUMENTATION MUST BE SUBMITTED.

Dependent Enrollment/Update Information: (Please complete for spouse and/or all dependent children under 19 years of age.)

SPOUSE NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SOCIAL SECURITY NUMBER		BIRTH DATE				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SOCIAL SECURITY NUMBER		BIRTH DATE				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SOCIAL SECURITY NUMBER		BIRTH DATE				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SOCIAL SECURITY NUMBER		BIRTH DATE				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SOCIAL SECURITY NUMBER		BIRTH DATE				

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 signing this form, I agree to continue coverage as provided in the Individual Dental Policy issued by Delta Dental of Oklahoma and acknowledge I have read the privacy policy detailed on the back of this form. 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 personal bank account until further notice. In lieu of a DDOK automatic draft of my designated personal bank account, I shall have the option of payment in full, in advance, for each annual coverage period commencing on the effective date of my individual coverage, such payment to be made by check or DDOK automatic draft of my designated account. Regardless of the payment method I elect, 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.

Policyholder's Signature: _____ **Date:** _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling in this program or updating any information from an earlier enrollment. If you have any questions about filling out this form, please contact our office.

Policyholder Information:

This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the policyholder. Please print clearly using black or blue ink.

Coverage Effective Date:

When valid enrollment documentation and payment is received by DDOK on the 1st through the 20th day of the month, coverage will be effective the first day of the month immediately following. When valid enrollment documentation and payment is received by DDOK on the 21st through the last day of the month, coverage will be effective the first day of the second month. Example: Enrollment documentation/payment received January 5, 2006—coverage effective date is February 1, 2006; enrollment documentation/payment received January 23, 2006—coverage effective date is March 1, 2006.

Payment Election:

Monthly Draft By DDOK, Account No. – Check this payment election if you wish DDOK to automatically draft the monthly cost of your individual policy from your designated personal bank account. The designated account number and a voided check is required if electing this payment method.

Annual Payment In Full By Check – Check this payment election if you wish to pay the annual cost of your individual policy by personal check payable to DDOK. This check will be processed electronically in our system and then voided.

Annual Payment In Full By DDOK Draft, Account No. – Check this payment election if you wish DDOK to draft the annual cost of your individual policy from your designated personal bank account. The designated account number and a voided check is required if electing this payment method.

Enrollment/Update:

This section should only be completed if you are: (1) changing your current eligibility information, (2) changing your payment election, or (3) terminating your benefits under the individual policy. *Note: Changing your payment election is allowed only on the policy anniversary date.*

Dependent Update:

This section should only be completed when: (1) enrolling dependents in the individual policy, or (2) if you are submitting dependent updates/changes to DDOK. (Please include both first and last names of any individuals being enrolled in the individual policy or for whom you are submitting an update or change. Dependent children age 19 or older are not covered under this policy and must apply as individual policyholders.

**DELTA DENTAL PLAN OF OKLAHOMA
INDIVIDUAL PRIVACY POLICY**

All companies that are part of the Delta Dental Plan of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality.

For this reason, and in compliance with the Gramm-Leach-Bliley Act of 1999, Delta Dental has developed a privacy policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental conducts which may contain your confidential information.

INFORMATION WE COLLECT - We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, our website, over the telephone and claims filed with Delta Dental. This information includes, for example, your name, address, Social Security number, date of birth and claim information. We use this information to process our Customers requests and claims, provide Customers with additional information about new products, and to comply with Federal and State laws.

UTILIZATION OF INFORMATION - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business to provide our Customers with services and products. We do this by allowing access to certain nonpublic personal information about our Customers and their transactions. Access to this information is restricted to individuals who require it in order to service Customer accounts or provide services to our Customers, and as permitted by law. Delta Dental reserves the right to disclose this information in these and other circumstances as allowed or required by law. HOWEVER, under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.

OUR SECURITY - We maintain physical, electronic, and procedural safeguards to protect the information we collect about our Customers. We consider this nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in the proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process. While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers; therefore, our Customer's confidential information is protected. If you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at **(800) 522-0188 or 405-607-2100 (in the Oklahoma City metro)**.