DELTA DENTAL®

Delta Dental of Nebraska

DELTAVISION®

Network Administrator: EyeMed℠
Underwritten by Delta Dental of Nebraska

Enrollment or Update Form for:
Individual and Family Dental Plans
Individual and Family Dental Plans + Vision Plans

Enroll online now at www.DeltaDentalNE.org/shop/ or complete this application and mail (along with a check) if applicable, to:

Delta Dental of Nebraska
Individual and Family Plans
PO Box 74008401
Chicago, IL 60674-8401

If you have any questions about filling out this form, please contact our Individual Customer Service at (855) 663-5677.

- ☐ 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 section must be completed for us to process your enrollment or update your records. **Please print clearly.**

Example A B C D E F 1 2 3 4 5 6

Subscriber Name (First) (M.I.) (Last)

Birth Date

Sex ◯ Male ◯ Female

Subscriber Social Security Number - Requested but not required

☐ Check here if this is a new address

Street Address

City State ZIP Code

Email Address (Optional)

Telephone Number

New Coverage / Change / Termination Effective Date *

(Requested date of new coverage, change in coverage or termination)

*New enrollments must start on the **first** of a future month
*Requested termination date must be the **last day** of the current or a future month (except in the case of death)
*If change, reason for change _____

Spouse Information (Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)

Spouse Name (First) (M.I.) (Last)

Birth Date

Sex ◯ Male ◯ Female

Dependent Child Information #1

Dependent Child Name (First) (M.I.) (Last)

Birth Date

Sex ◯ Male ◯ Female

Dependent Child Information Continued: #2

Dependent Child Name (First) (M.I.) (Last)

Birth Date Sex ○ Male ○ Female

#3 - Dependent Child Name (First) (M.I.) (Last)

Birth Date Sex ○ Male ○ Female

#4 -Dependent Child Name (First) (M.I.) (Last)

Birth Date Sex ○ Male ○ Female

#5 - Dependent Child Name (First) (M.I.) (Last)

Birth Date Sex ○ Male ○ Female

For additional dependents, please provide complete information on a separate piece of paper and include with this form.

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

Dental Plan Options (select only one):

- ❑ Delta Dental Individual and Family℠ – Plan A ($50 Deductible/$2,000 Annual Plan Maximum)
- ❑ Delta Dental Individual and Family℠ – Plan B ($100 Deductible/$1,200 Annual Plan Maximum)
- ❑ Delta Dental Individual and Family℠ – Plan C ($100 Deductible/$750 Annual Plan Maximum)

Dental + Vision Plan Options (select only one)

- ❑ Delta Dental Individual and Family℠ – Plan A with DeltaVision®, Network Administrator EyeMed
- ❑ Delta Dental Individual and Family℠ – Plan B with DeltaVision®, Network Administrator EyeMed
- ❑ Delta Dental Individual and Family℠ – Plan C with DeltaVision®, Network Administrator EyeMed

Payment Frequency:

- ❑ Annual (If you are paying by check, you must choose this option and pay the amount due in full)
- ❑ Monthly (If you are paying by credit card or automatic withdrawal, please choose this option)

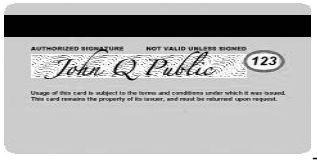
Choose the payment method:

❑ Check payable to Delta Dental (you may pay by check only if you choose an annual payment)

❑ MasterCard ❑ VISA ❑ Discover ❑ American Express

Card Number Exp. Date –

Cardholder 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)

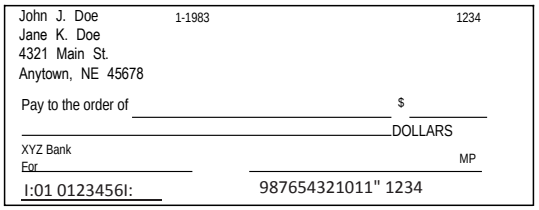
Street Address

City State ZIP Code –

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for premiums 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



Routing number Account number

Bank Name

❑ Checking Account
❑ Savings Account

Routing Number

Account Number

I hereby authorize Delta Dental of Nebraska, its subsidiaries, and its affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental of Nebraska 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 _____

Agent Information If an agent is assisting in the purchase of this policy, please enter the agent information below:

Agent Name _____ Agent NPN _____

AuthorizationandVerification

I have read the information contained in the application and choose to enroll or make the changes indicated. I understand the benefits and restrictions of this plan as stated in the material provided with the application. I certify the information contained in this application is true and complete. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim against civil damages. I understand my enrollment is subject to receipt of payment and verification of funds. The start and end dates of coverage will be determined by Delta Dental of Nebraska. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting cancellation of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand that I must enroll for one full year and if I terminate this contract or discontinue at any time, for any reason re-enrollment restrictions will apply, according to the contract.

Subscriber's Signature _____ Date _____

This policy is not Medicare supplement coverage. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Discrimination is against the law. Delta Dental of Nebraska and its affiliates, collectively referred to in this document as "Delta Dental of Nebraska." Delta Dental of Nebraska complies with applicable federal civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

Delta Dental of Nebraska provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). This plan provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need these services, please call the phone number on the back of your ID card. If you believe Delta Dental of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by contacting us by phone at 612-224-3300 or 877-268-3384; by fax at 612-460-3102; email: legalne@deltadentalne.org; or by mail at: Delta Dental of Nebraska Attn: Chief Compliance Officer 500 Washington Avenue South, Suite 2060 Minneapolis, MN, 55415.

You may file a grievance in person or by mail, fax or email. If you need help filing a grievance, please call the number on the back of your ID card. You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal available online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.
You may also contact them by phone at 1-800-368-1019, 1-800-537-7697 (TDD). You may contact them by mail at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

FOREIGN LANGUAGE NOTIFICATIONS

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayudas y servicios auxiliares para proporcionar información en formatos accesibles. Llame al 1-855-643-3582 (TTY: 711) o hable con su proveedor.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các phương tiện hỗ trợ và dịch vụ phù hợp để cung cấp thông tin theo định dạng dễ tiếp cận cũng có sẵn miễn phí. Gọi 1-855-643-3582 (TTY: 711) hoặc nói chuyện với nhà cung cấp của bạn.

ကရင် (Karen)
အကြောင်းကြားချက်: သင့်ရဲ့ဘာသာစကားကိုပြောရင် ဘာသာစကားအကူအညီဝန်ဆောင်မှုများကို အခမဲ့ရရှိနိုင်သည်။ အချက်အလက်များကို ရယူနိုင်ရန် သင့်အတွက် သင့်လျော်သော အကူအညီများနှင့် ဝန်ဆောင်မှုများလည်း အခမဲ့ရနိုင်သည်။ 1-855-643-3582 (TTY: 711) ကို ဖုန်းဆက် သို့ မဟုတ် သင်၏ပံ့ပိုးသူနှင့် စကားပြောပါ။

Soomaali (Somali)
DIGNIIN: Haddii aad ku hadasho Soomaali, adeegyada caawinta luqadda ee lacag la'aanta ah ayaa kuu heli kara. Kaalmooyin iyo adeegyo kale oo ku habboon si loo bixiyo macluumaad qaabab la heli karo ayaa sidoo kale bilaash ah. Wac 1-855-643-3582 (TTY: 711) ama la hadal bixiyahaaga.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Auch geeignete Hilfsmittel und unterstützende Dienstleistungen, um Informationen in barrierefreien Formaten bereitzustellen, sind kostenlos verfügbar. Rufen Sie 1-855-643-3582 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter.

العربية (Arabic)
تنبيه :إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية .كما تتوفر المساعدات والخدمات الملائمة لتقديم المعلومات بصيغ يمكن الوصول إليها مجاناً .اتصل على الرقم 1-855-643-3582 (TTY: 711) أو تحدث إلى مقدم الخدمة الخاص بك.

Afaan Oromoo (Oromo)
MEEKAA: Yoo Afaan Oromoo dubbattu, tajaajilawwan gargaarsa afaan bilisaa siif kennameera. Deeggarsa fi tajaajilawwan garaagarummaa odeeffannoo akka argachuuf ni kennama. Bilbila 1-855-643-3582 (TTY: 711) tuquu yookaan tajaajiltuu kee waliin haasa'uu.

中文 (Chinese Simplified)
注意： **如果您**讲中文，我们提供免费的语言帮助服务。还提供免费的辅助工具和服务，以便以可访问的格式提供信息。请拨打 1-855-643-3582（TTY: 711）**或与您的服务**提供者联系。

Lus Hmoob (Hmong)
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob, muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-855-643-3582 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

한국어(Korean)
주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 및 지원 서비스도 무료로 제공됩니다. 1-855-643-3582 (TTY: 711)로 전화하시거나 제공자와 상담해 주십시오.

Kurdî (Kurdish**)**
TÊKİLDARÎ: Heke tu bi kurdî diaxivî, xizmetên alîkariya zimanê bêpere hene ku ji bo te heye. Hinek alîkarî û xizmetên piştgirî ji bo peyda kirina agahdariyê di formên gihîştinê de jî bêpere hene. Bi hejmar 1-855-643-3582 (TTY: 711) re telefon bike an jî bi peyda kirê xwe re reş bike.

Français (French)
ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-643-3582 (TTY : 711) ou parlez à votre fournisseur.

ລາວ (Laotian)
ແຈ້ງເຕືອນ: ຖ້າເຂົ້າໃຊ້ພາສາລາວ,
ບໍ່ເສຍຄ່າບໍ່ມີໃຫ້ບໍ່ເພີ່ມສະຫນອງບໍ່ເປັນບໍ່ມີໃຫ້.
ບໍ່ເສຍຄ່າບໍ່ມີໃຫ້ສໍາລັບການເຂົ້າໄປຂະບວນທີ່ສະດວກ
ສະເຫນອງຂໍ້ມູນ. ໂທໄປ 1-855-643-3582 (TTY: 711) ຫຼື
ສົນທະນາກັບຜູ້ໃຫຫມ່ເພີ່ມອອກ.

Tagalog (Tagalog)
PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, mayroon kang access sa mga libreng serbisyo ng tulong sa wika. Magagamit din nang libre ang mga naaangkop na kagamitan at karagdagang serbisyo upang magbigay ng impormasyon sa mga format na maa-access. Tumawag sa 1-855-643-3582 (TTY: 711) o makipag-usap sa iyong tagapagbigay.

Русский (Russian)
В Н И М А Н И Е: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Также бесплатно доступны соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по номеру 1-855-643-3582 (TTY: 711) или обратитесь к вашему провайдеру.

فارسی" (Fārsi/Persian)
توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان کمک‌زبان در دسترس شماست. همچنین، ابزارها و خدمات کمکی مناسب برای ارائه اطلاعات به قالب‌های قابل دسترسی نیز به صورت رایگان در دسترس هستند. تماس بگیرید یا با ارائه‌دهنده (TTY: 711) با شماره 3582-643-855-1 خود صحبت کنید.

አማርኛ (Amharic)
ገልጻችሁ: እንደ አማርኛ ብትናገሩ ነጻ የቋንቋ እርዳታ አገልግሎት እንዲገኝዎት እንችላለን። መረጃን በእንደሆኑ ቅርጸ ቅርጸቶች ለማቅረብ ሆኖ በተጨማሪ ማስተካከያ ድጋፍና አገልግሎቶች እንደሆኑ እንግዲህ በነጻ ይገኛሉ። በቁጥር 1-855-643-3582 (TTY: 711) ያነጋግሩ ወይም ከአገልግሎት ተመን እንዲደውልዎት እንዲችሉ ያገልግሉልዎታል።

မြန်မာ (Burmese)
သတိပြုပါ: သင်ဗမာလိုပြောပါက၊
အခမဲ့ဘာသာစကားအကူအညီဝန်ဆောင်မှုများရရှိနိုင်ပါသည်။
လက်ခံရရှိနိုင်သောအမျိုးအစားများတွင်သတင်းအချက်အလက်များပေးရန် လိုအပ်သော ကူညီမှုများနှင့်
ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ရနိုင်ပါသည်။ 1-855-643-3582 (TTY: 711) သို့ ဖုန်းခေါ်ပါ သို့မဟုတ် သင်၏ပေးအပ်သူနှင့်
ပြောပါ။

नेपाली (Nepali)
सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचामा जानकारी प्रदान गर्न उपयुक्त सहायक साधन र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-643-3582 (TTY: 711) मा कल गर्नुहोस् वा तपाईंको प्रदायकसँग कुरा गर्नुहोस्।