DELTA DENTAL

Delta Dental use only

# Veterans Affairs Dental Insurance Program (VADIP)

## Enrollment application

Delta Dental of California, P.O. Box 537007, Sacramento, CA 95853-7007
855-370-3303 | deltadentalins.com/vadip

Print clearly and complete all applicable sections. All information is required for your application to be processed.

### Primary

Veteran's last name _____ First name _____ MI _____ Sex: ☐ Male ☐ Female

Date of birth (MM/DD/YYYY) _____ Social Security number _____

**Applicant to be enrolled (check all that apply):** ☐ Veteran ☐ CHAMPVA dependents

**Enrollment plan options (check one):** ☐ Enhanced ☐ Comprehensive ☐ Prime

**How did you hear about us?**

☐ Neighbor/friend ☐ Veteran's newspaper ☐ Benefits fair
☐ Marketing representative ☐ Conference/convention ☐ Internet
☐ VA health care professional ☐ Other: _____

### Members to be enrolled

| Full legal name | Date of birth | Social Security number | Sex |
|---|---|---|---|
| Veteran — ☐ Same as above | | | ☐ M ☐ F |
| | | | ☐ M ☐ F |
| | | | ☐ M ☐ F |
| | | | ☐ M ☐ F |
| | | | ☐ M ☐ F |

### Primary beneficiary contact information (account holder)

Residential address (street, city, state, ZIP code) _____

Mailing address ☐ Same as above _____

Telephone number _____

### Sign up for electronic delivery

☐ Yes, I would like to receive my Welcome Letter and Explanation of Benefits (EOB) electronically. Email address (required): _____

## Recurring payment options (required)

Upon enrollment, an initial payment of a one-month premium will be charged to your preferred method below. Ongoing payments of your monthly premiums will be scheduled to the same account. Please complete the one of the two options provided below.

(1) Electronic Funds Transfer (EFT) from your savings or checking account each month; (2) Recurring Credit Card (RCC) payment authorization from a credit card each month.

**Note:** If a payment is returned for insufficient funds, you authorize Delta Dental to charge for the original amount of the transaction, as well as a return fee, up to the maximum amount allowed by law.

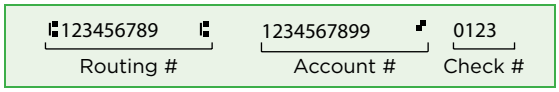
### Electronic Funds Transfer (EFT)

Name of financial institution _____ Name on bank account _____

Type of account: ☐ Checking ☐ Savings

Routing number (9-digit): ___ ___ ___ ___ ___ ___ ___ ___ ___

**Example:**




Bank account number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

**Note:** Please confirm with your banking institution that your account can accept Automatic Clearing House (ACH) debits and that you have provided the correct ABA for ACH transactions.

### Recurring Credit Card (RCC) Payment

Credit card type: ☐ Visa® ☐ MasterCard® ☐ Discover®

Credit card number: _____ Exp. date: _____ CVV (3-digit on back of card): _____

Cardholder name (as it appears on credit card): _____

Billing address (if different from residential address): _____

## Acknowledgement for EFT or RCC enrollment (required)

**Initial next to each statement to agree to the terms and conditions**

_____ **Amount of payment: For EFT:** The appropriate premium amount will be deducted from your bank account on the sixth of every month or the next business day, depending on your financial institution. **For RCC:** The appropriate premium amount will be deducted from your credit card on the sixth of every month or the next business day, depending on your financial institution.

_____ **Right to stop automatic payments:** You have the right to stop automatic payments at any time; however, doing so may adversely affect your dental insurance program enrollment. To stop your automatic payments, contact us by phone/written notice. Cancellation must be received three business days before the next payment due date. You must provide information for an alternate payment method (i.e., a new bank account or credit card) at the time you cancel your current payment method. Failure to do so in a timely manner could result in the termination of your account and a 12-month re-enrollment lockout. **Phone:** 855-370-3303, **Address:** Delta Dental of California, PO BOX 537007, Sacramento 95853-7007

_____ **Your responsibility**: This EFT or RCC payment arrangement will be terminated if your financial institution refuses payment due to insufficient funds or other reason. Second attempts to deduct payment will not be made using the same payment method information. If we receive information for a new payment method after the attempt to deduct payment has been declined, we will use the new information provided to attempt a deduction for the past-due balance.

_____ I authorize Delta Dental to charge the credit card indicated on this authorization form or withdraw funds from my bank account for payment of my monthly dental program premiums according to the terms outlined above. If the above-noted payment date for EFT or RCC falls on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it by phone or in writing, and I agree to notify Delta Dental by phone or in writing of any changes in my account information or termination of this authorization at least three days prior to the next billing date. I certify that I am an authorized user of this bank account/credit card and that I will not dispute the scheduled payments with my financial institution provided the transactions correspond to the terms indicated in this authorization form.

## Enrollment Agreement (required)

This Enrollment Authorization must be signed below by the Veteran or CHAMPVA beneficiary. An individual with power of attorney (POA) may sign for either; however, the entire copy of the valid POA must be submitted with the Enrollment Authorization.

This is my application for coverage under the Veterans Affairs Dental Insurance Program (VADIP). I understand that enrollment is subject to verification of eligibility and receipt of one month's premium payment. I understand that coverage does not begin upon deposit of my initial premium payment. Coverage will be effective the first day of the month after receipt and acceptance of my application. I must remain enrolled for a minimum of 12 months. Termination is not automatic upon fulfill-ment of this period and must be initiated by the subscriber. I understand that I am responsible for full payment of any dental services provided prior to the effective date or after the termination date of the policy.

Beneficiary signature: _____ Date: _____

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