DELTA DENTAL

Delta Dental of Arkansas
P.O. Box 1596
Indianapolis, IN 46206-1596
FAX: 888-984-7161
Service@mysmilecoverage.com

INDIVIDUAL CHANGE FORM

Requested Effective Date		
Month	Day	Year
	1st	

Policy Effective Date: All Delta Dental policies will have an effective date of the first of the month following receipt of complete change form. Change form must be received in our offices by the 26th of the month prior to the requested effective date. (Example: Received by January 26th to be effective February 1st.) Change forms received after the 27th of the month will be made effective on the 1st of the following month. (Example: Received January 27th, will be effective March 1st.)

1. CURRENT POLICY HOLDER INFORMATION

First Name:____________________ **M.I.**_____ **Last Name:**____________________ **Date of Birth:** ____/____/______ **Sex:** _____

Street Address: ____

City: ____ **State:**__________ **Zip:** ______________

Social Security/Member ID:____________________ **Phone Number:**____________________ **Email:**______________________

CHANGES TO BE MADE

Please skip sections that do not apply to the change(s) you are making.

2. ADDRESS CHANGES

NEW MAILING ADDRESS **Street:**____

City:________________________________ **State:**________ **Zip:**____________

3. NAME CHANGE

NEW **First Name:**______________________________ **M.I.**________ **Last Name:**____________________________

4. CHANGE IN PLAN SELECTION

COVERAGE CHANGES ☐ **Delta 500 (AR500)** ☐ **Delta 1000 (AR1000)** ☐ **Delta 1300 (AR1300)**

☐ **Add Vision to my existing dental plan** ☐ **Remove Vision from a dental plan**

5. LIST ALL MEMBERS TO BE AFFECTED BY A CHANGE

☐ **Individual** ☐ **Individual and Spouse** ☐ **Individual and Child(ren)** ☐ **Individual, Spouse, and Child(ren)**

	Last Name (if different)	First Name	MI	Relationship	Sex M/F	Birthdate Month/Day/Year
1. ☐ Add / ☐ Remove						
2. ☐ Add / ☐ Remove						
3. ☐ Add / ☐ Remove						
4. ☐ Add / ☐ Remove						

Do all proposed insureds reside in Arkansas? ☐ Yes ☐ No **If no, provide a reason:** ____________________________

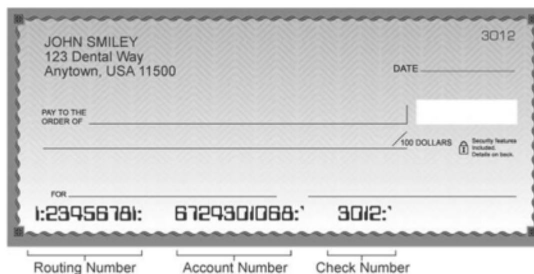
6. POLICY TERMINATION

TERMINATE POLICY ☐ **Yes** ☐ **No** **Termination Date:** ____/____/_______

7. CHANGE IN PAYMENT METHOD*

***Only complete this section if you want to change your payment method to something other than what we have on file.**

CHANGE IN BANKING INFORMATION (Please Attach a voided check or deposit slip to application.)



Bank Draft (EFT): ☐ **Monthly** ☐ **Annually**

Bank Account Type: ☐ **Checking** ☐ **Savings**

Bank Routing Number:_______________________________________

Bank Account Number:_______________________________________

Authorization: I authorize Delta Dental of Arkansas, Inc. (DDAR) and the BANK indicated above to debit my DDAR premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the bank's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my DDAR coverage, unless DDAR has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

Bank Account Holder's Signature:_______________________________________ **Date:** ____ /____ /_______

CHANGE IN CREDIT CARD INFORMATION

Credit Card: ☐ **Monthly** ☐ **Annually**

Credit Card Type: ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Name on Credit Card:_______________________________________

Credit Card Number:_______________________________________ **Expiration Date (MM/YYYY):**____ /________

CV2 Number (last 3 digits located in signature block on back of card):______

Credit Card Holder's Signature:_______________________________________ **Date:** ____ /____ /_______

CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. 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 fines and confinement in prison.

Policy Holder's Signature:_______________________________________ **Date:** ____/____/_______

OR

Parent/Legal Guardian's Signature:_______________________________________ **Date:** ____/____/_______
(If policy is for a minor)