Delta Dental of Arkansas
P.O. Box 15965, Little Rock, AR 72231
individualservices@deltadentalar.com

REQUESTED EFFECTIVE DATE		
MONTH	DAY	YEAR
	1st	

Individual and Family Coverage Change Form

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.)

CURRENT POLICYHOLDER INFORMATION		
First Name:	M.I.:	Last Name:
Date of Birth: / /	Social Security Number:	Sex:
Mailing Address:		
City:	State:	ZIP:
Telephone:	Email:	

CHANGES TO BE MADE (please skip sections that do not apply to the change(s) you are making)				
NAME	First:	M.I.:	Last:	
ADDRESS, EMAIL OR TELEPHONE NUMBER	Address:			
	City:	State:	ZIP:	
	Email:	Telephone:		
To whom does this change apply?	☐ Policyholder	☐ Covered Dependent under age 18	☐ Covered Dependent age 18+	
PLAN SELECTION CHANGE	**Please select the plan to which you wish to change.** ☐ Delta 500 (AR500) ☐ Delta 1000 (AR1000) ☐ Delta 1300 (AR1300) ☐ Add vision to my existing dental plan ☐ Remove vision from a dental plan			
COVERAGE LEVEL CHANGE (Please provide details for each member to be added or removed.)				
☐ Individual	☐ Individual and Spouse	☐ Individual and Child(ren)	☐ Family	
☐ Add ☐ Remove	Last (if different):	First:		M.I.:
	Relationship:	Sex:	Date of Birth: / /	
☐ Add ☐ Remove	Last (if different):	First:		M.I.:
	Relationship:	Sex:	Date of Birth: / /	
☐ Add ☐ Remove	Last (if different):	First:		M.I.:
	Relationship:	Sex:	Date of Birth: / /	
☐ Add ☐ Remove	Last (if different):	First:		M.I.:
	Relationship:	Sex:	Date of Birth: / /	
Do all proposed insured reside in Arkansas? ☐ YES ☐ NO. If no, provide reason:				
CANCEL COVERAGE	If you need to cancel your coverage, please check "Yes" and indicate the date your coverage is to be canceled. Cancel coverage? ☐ YES Date Coverage is to be Canceled: / /			

PAYMENT METHOD CHANGE Only complete this section if you want to change your payment method to something other than what we have on file.	***If you wish to make changes to your payment method using a credit card, please call (844) 788-7627.***
CHANGE IN BANKING INFORMATION **(Attach a VOIDED check or deposit slip to application)**	
Bank Draft (EFT): ☐ Monthly ☐ Annually	
Account Type: ☐ Checking ☐ Savings	
Routing Number:	
Account Number:	Routing Number Account Number Check 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: _____ / _____ / ________

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)