

*Iowa State University Student and Scholar*  
**Graduate Assistants & Pre/Postdoctoral Associates  
Dental Program Enrollment Form 2008-2009**

**TO ENROLL, SIMPLY COMPLETE THIS FORM AND DELIVER  
WITH A CHECK TO:** ISU Student & Scholar Insurance Office Room 0570  
in Beardshear Hall or mail to the address at the bottom of this form.

You are employed as \_\_\_\_\_ Grad Assistant \_\_\_\_\_ Pre/Postdoctoral Associate

Application for:  New Enrollment  Change in Enrollment  Renewal

New Enrollment coverage is for (check one):

Self  Self & Spouse/Domestic Partner  
 Self & Child(ren)  Self, Spouse/Domestic Partner & Child(ren)

Change in current enrollment (check the item(s) that apply):

Address change  Payment method change  
 Add spouse/domestic partner and/or child(ren)

Insured's Name

\_\_\_\_\_

Last/Family                      First                      M.I.

Local Address (Home or Office)

City, State, Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

University ID Number \_\_\_\_\_

GENDER  Male  Female

Birth Date (mo/date/yr) \_\_\_\_\_

**METHOD OF PAYMENT**

**Graduate Student and Pre/Postdoctoral Associates** —payroll deduction only.

**LIST DEPENDENTS BELOW.** Complete this section only if you are covering your  
spouse, domestic partner or child(ren).

Spouse/Domestic Partner Name \_\_\_\_\_

Birth Date (mo/date/yr) \_\_\_\_\_

Male  Female

Child Name \_\_\_\_\_

Birth Date (mo/date/yr) \_\_\_\_\_

Child Name \_\_\_\_\_

Birth Date (mo/date/yr) \_\_\_\_\_

If you or anyone named on this enrollment form have dental insurance through Delta  
Dental of Iowa or any other company, complete the following:

Insured Person(s) \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

6-08

**Agreement Certification**

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for the coverage sponsored by Iowa State University, offered by Delta Dental of Iowa.

I certify that after this enrollment form was completed, I carefully and fully read it that the statements and answers set forth are full, true and correct, to the best of my knowledge and belief and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental of Iowa will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or conceal any material fact, Delta Dental of Iowa will be entitled to declare the dental contracts applied for void and refuse allowance of benefits to any person there under.

I authorize any Delta Dental provider to release dental records to Delta Dental of Iowa when reasonable related to the care for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

I have read and understand the Agreement Certification language on this form.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Complete the above form, sign, date and mail to:

ISU Student Insurance Office  
0570 Beardshear Hall  
Ames, IA 50011-2033

Attention: Wanda Kellogg

If you have questions, please call 1-800-544-0718

Or send an e-mail to: [enrollment@deltadentalia.com](mailto:enrollment@deltadentalia.com)