

Iowa State University Student and Scholar
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.

Period of Enrollment (check one):

***Please refer to premium table for coverage period eligibility.**

- FULL YEAR—8/11/08-8/09/09 (enrollment deadline is September 15, 2008)
 SPRING/SUMMER—1/1/09—8/09/09 (enrollment deadline is January 26, 2009)
 SUMMER—6/1/09—8/09/09 (enrollment deadline is June 17, 2009)

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

Undergraduate or Graduate Student--Full payment must be submitted with this application. Graduate Assistant—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 _____

4-08

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 thereunder.

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 & Scholar 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

*The ISU Student and Scholar Dental Program is separate from the ISU Student and Scholar Health Insurance Program. Students who enroll in the Dental Program are responsible for its full cost.