

PROGRAM COST AND PAYMENT OPTION (choose only one)

Check appropriate box based on the information below:

- | | | |
|--------------------------|--|----------|
| | Plan CAA55 | |
| <input type="checkbox"/> | Individual annual Premium | \$ 80.76 |
| <input type="checkbox"/> | Individual plus one dependent annual Premium | \$130.68 |
| <input type="checkbox"/> | Individual plus two or more dependents annual Premium | \$191.16 |
| | One-time non refundable Enrollment Fee (required for new enrollment) | \$ 10.00 |
| | TOTAL | \$ _____ |

Indicate effective date:

Month	Day	Year

This Enrollment and Payment Authorization Form and your check or money order, if applicable, must be received by the 21st day of the month for your coverage to be effective on the first day of the following month.

I wish to enroll in the DeltaCare USA Individual/Family Dental Program. I acknowledge that I have read the Disclosure Form/Contract and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of Delta Dental, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Delta Dental provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

PAYMENT OPTIONS

- CHECK/MONEY ORDER PAYMENT OPTION
Please make check or money order payable to Delta Dental of California.

You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of coverage.

- CREDIT CARD PAYMENT OPTION

- VISA MASTERCARD DISCOVER AMERICAN EXPRESS

CARD # _____

EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CARD

SIGNATURE _____

DATE _____

By signing above you authorize Delta Dental of California to charge your credit card account for the cost of the DeltaCare USA Program.

Note: Any credit card refunds under the Program may be made by check or credit card.

Signature: _____ Date _____

Return form to Delta Dental of California at P.O. BOX 660138, Dallas, TX 75266-0138 or enroll online at www.deltadentalins.com
CAA55