

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: \_\_\_\_\_ fax: \_\_\_\_\_

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction or credit card), quarterly (every three months) or annually (once a year). Send a voided check for your 1st months premium.

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...

 **DELTA DENTAL**

# Vision Monthly Rates

	Signature Choice	Exam Plus
<b>Member</b>	\$7.54	\$3.00
<b>Member + 1</b>	\$15.11	\$6.00
<b>Member + Family</b>	\$24.34	\$9.00

## Application Step 1

### Benefits Association Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<p>"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthly membership fee is \$1.00 and is included in the monthly rates."</p> <p><b>Member Signature:</b></p> <p>_____</p> <p>Date _____</p>
Home Phone	Street					
	City	State	Zip			

For additional information email MorganWhiteGroup at [marketing@morganwhite.com](mailto:marketing@morganwhite.com) or call 1-800-800-1397

**Sign Here**

## Application Step 2 Dental For Everyone Enrollment Card

<b>Plan Selection:</b> <input type="checkbox"/> Platinum Plan <input type="checkbox"/> Gold Plan <b>Network Selection:</b> <input type="checkbox"/> Delta Dental Premier® <input type="checkbox"/> Delta Dental PPO <b>Type of Coverage</b> <input type="checkbox"/> Member <input type="checkbox"/> Member + 1 <input type="checkbox"/> Member + Family <b>Optional Vision Coverage:</b> <input type="checkbox"/> Exam Plus <input type="checkbox"/> Signature Choice					<b>METHOD OF PAYMENT</b> <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Bankdraft: This is my authorization for Morgan-White Administrators, Inc., on behalf of Delta Dental Insurance Company to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn. Name of Bank: _____ Name as it appears on Check: _____ Routing Number (Bottom Left Corner of Check) _____ Account Number (2nd set of numbers on bottom) _____ <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card #: _____ Exp. Date _____/_____ Security Code _____ (3 digit code on back of card)	
Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Home Phone	Street					
	City	State	Zip			
	E-mail address:					
<b>LIST ALL DEPENDENTS TO BE COVERED BELOW</b>						
Last Name (if different)	First Name	Initial	Birthdate	Sex		
2. Spouse				<input type="checkbox"/> M <input type="checkbox"/> F		
3. Dependents				<input type="checkbox"/> M <input type="checkbox"/> F		
4.				<input type="checkbox"/> M <input type="checkbox"/> F		
5.				<input type="checkbox"/> M <input type="checkbox"/> F		
6.				<input type="checkbox"/> M <input type="checkbox"/> F		
7.				<input type="checkbox"/> M <input type="checkbox"/> F		
<p>"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been accepted and approved by Delta Dental Insurance Company and (2) the agent does not have the authority to make or alter any contract or waive any of Delta Dental's other rights or requirements."</p> <p>Association Member's Signature _____ Date _____</p>						

**For Agent Use Only** AGENT NAME (if applicable): \_\_\_\_\_

AGENT # (Your state license #): \_\_\_\_\_