DELTA DENTAL

OSMA Enrollment/Update

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS, EXPLANATION OF CODES, AND PRIVACY POLICY STATEMENT.

Delta Dental of Oklahoma
P.O. Box 54709
Oklahoma City, OK 73154

Fax to:
405-607-4781
Attn: Client Services

GROUP# 9 8 5 2 — SUBGROUP# ____

Subscriber Information: *(please complete in ink)*

SUBSCRIBER NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ M ☐ F | MARTIAL STATUS ☐ M ☐ S

SUBSCRIBER SSN# ___ — __ — ____ | BIRTH DATE __ – __ – __ | FULL-TIME HIRE DATE __ – __ – __ | COVERAGE EFFECTIVE DATE __ – __ – __

ADDRESS | PHONE ___ – ___ – ____

CITY | STATE | ZIP | CHECK HERE IF THIS IS A NEW ADDRESS ☐

E-MAIL ADDRESS

Payment Election: ACCT. NAME:_______________ **BANK NAME:**_______________

☐ BANK ROUTING NO._______________ ☐ MONTHLY DRAFT BY DDOK, ACCOUNT NO._______________

Enrollment/Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: ____/______/_______

TERMINATION REQUIREMENT:

PLEASE NOTE THAT YOU MUST PROVIDE A MINIMUM OF 30 DAYS WRITTEN NOTICE TO DELTA DENTAL OF OKLAHOMA.

☐ CHANGE IN CURRENT ELIGIBILITY STATUS FOR: ☐ SUBSCRIBER ☐ DEPENDENTS

REASON FOR CHANGE: ☐ DIVORCE ☐ MARRIAGE ☐ NAME CHANGE ☐ ADOPTION/LEGAL GUARDIANSHIP*

☐ OTHER_______________

***** *LEGAL DOCUMENTATION MUST BE SUBMITTED.***

Dependent Enrollment/Update Information: *(Please complete for spouse and/or all dependent children)*

SPOUSE NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ___ — __ — ____ | BIRTH DATE __ – __ – __

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ___ — __ — ____ | BIRTH DATE __ – __ – __

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ___ — __ — ____ | BIRTH DATE __ – __ – __

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ___ — __ — ____ | BIRTH DATE __ – __ – __

DEPENDENT CHILD NAME (LAST) | (FIRST) | (M.I.) | SUFFIX | SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER ___ — __ — ____ | BIRTH DATE __ – __ – __

WARNING: Any person who know ingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of any insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

ACKNOWLEDGEMENT and AUTHORIZATION: By signing t his form, I agree t o continue coverage as provided i n the contract between OSMA and Delta Dental of Oklahoma and acknowledge I have read the privacy policy detailed on the back of this form. To cover the cost of my dental benefits for which I have made request, and for which I am or may become insured, I hereby authorized Delta Dental to draft my designated personal bank account until further notice. I understand and agree that failure to make funds available in sufficient amounts ot cover the cost of my dental benefits for which I have made request shall result in the termination of my coverage effective on the paid-through date reflected in DDOK records at the time of such failure.

Subscriber's Signature: _______________ Date: _______________

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or update/changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the primary subscriber. Please print clearly in ink.

Full-Time Hire Date:	The date you were hired with your employer.
Coverage Effective Date:	The date Delta Dental coverage takes effect for you (and/or your dependents, if enrolled).

Payment Election:

Monthly Draft By DDOK, Account No. - This payment election is for DDOK to automatically draft the monthly cost of your individual policy from your designated personal bank account. The designated account number and a voided check is required if electing this payment method.

Enrollment/Eligibility Update Information - This section should only be completed if your are: (1) enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or (3) if you are making changes to your current enrollment information.

New Enrollment:	Check for first time enrollment for yourself or your eligible dependents.
Reinstatement:	Check for reinstatement coverage for yourself or your eligible dependents.
Termination of Benefits:	Check only if you are terminating Delta Dental coverage for yourself or a family member.

Delta Dental of Oklahoma
Privacy Policy

Delta Dental of Oklahoma Individual Privacy Policy

All companies that are part of the Delta Dental Plan of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality.

For this reason, and in compliance with the Gramm-Leach-Bliley Act of 1999, and HIPPA, Delta Dental has developed a privacy policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental conducts which may contain your confidential information.

INFORMATION WE COLLECT - We collect and maintain personal, nonpublic information we receive from Customers directly through applications, claims, enrollment forms, our website, and over the telephone or in person, from providers, agents, clearinghouses, and government agencies. This information includes, for example, your name, address, Social Security Number, date of birth, and claim information. We use this information to process our Customers' requests and transactions, provide Customers with additional information about new products, and to comply with federal and state laws.

UTILIZATION OF INFORMATION - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business to provide our Customers with services and products. We do this by allowing access to certain nonpublic personal information about our Customers and their transactions. Access to this information is restricted to individuals who require it in order to service Customer accounts or provide information to our Customers, and as permitted by law. Delta Dental reserves the right to disclose this information in these and other circumstances as allowed or required by law. HOWEVER, under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.

OUR SECURITY - We maintain physical, electronic, and procedural safeguards to protect the information we collect about our Customers. We consider this nonpublic personal information to be confidential and treat it as such. The personnel who have access to this information are trained in the proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process. While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers; therefore, our Customers' confidential information is protected. If you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at (800) 522-0188 or 405-607-2100 (in the Oklahoma City metropolitan area).

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