DELTA DENTAL®

ENROLLMENT FORM

Personal Information Please fill out this form entirely. Incomplete forms will delay your application.

BROWN UNIVERSITY RETIREE	Social Security Number	Date of Birth (MM/DD/YYYY)
First Name	Last Name	

Street Address / P.O. Box Number	City	State	Zip Code
Email Address	Telephone Number		

Coverage Type & Premium Rates

Monthly Premium: ___Individual $57.89 Rate effective January 1, 2016 - December 31, 2016

Coverage Action Please select one: ___ New Enrollee ___ End Coverage ___Change Name/Address/Billing

Enrollment Status

Are you the: ☐ Brown University Retiree ☐ Spouse of Brown University Retiree

Year the Brown University Employee Retired _____

Coordination of Benefits (Additional Dental and Medical Coverage)

Are you or any of your family members covered by another dental plan? ___YES ___NO Is this an ____ Individual or _____FamilyPlan? (Check one.)

Other Dental Insurance Name:_____ Other Dental Insurance Address:_____

Policyholder Name:_____ Policy Number:_____

Are you or any of your family members covered by a medical plan? ___YES ___NO Is this an ____ Individual or _____FamilyPlan? (Check one.)

Other Medical Insurance Name:_____ Other Medical Insurance Address:_____

Policyholder Name:_____ Policy Number:_____

Method of Payment (See back for details.)

Please check ☑ a payment type, and fill in the appropriate information.

☐ **A. Monthly Direct Withdrawal from Bank Account:** **Type:** ☐ **Checking** ☐ **Savings**

Name on Bank Account:_____

Bank Name:_____ Bank Address:_____

Routing Number:_____ Bank Account Number:_____

☐ **B. Monthly Credit Card Payment:**

Name (exactly as it appears on credit card):_____

Credit Card Type: ☐ MasterCard ☐ Visa ☐ Discover Credit Card Number:_____ Expiration Date:_____ (MM/YYYY)

Authorizing Signature:

I certify that all information is true and correct to the best of my knowledge. I understand that the start date and cancellation date of my insurance coverage will be determined by Delta Dental of Rhode Island. If I have selected Payment Method A or B, I authorize Delta Dental to withdraw funds from my bank account or charge my credit card no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. I understand that if funds/available credit balances are not available or payment is not otherwise timely made, I will no longer be eligible for coverage. I have read and understand the information on both the front and back of this form.

_____

Your signature (Form will not be processed without signature.) **Date**

Please mail this form and your payment to Delta Dental of Rhode Island, P.O. Box 1517, Providence, RI 02901-1517.

DELTA DENTAL®

BROWN UNIVERSITY
RETIREE DENTAL PLAN

P.O. BOX 1517
Providence, RI 02901-1517
800-843-3582
www.deltadentalri.com

Please read the following information regarding the plan's eligibility, coverage and payment guidelines.

Eligibility Information

You must be a Brown University Retiree to qualify and remain eligible for coverage.

Coverage Type and Premium

You and your spouse are eligible for Delta Dental coverage as individual members. Rates are guaranteed for the entire coverage period. Prior to the end of a coverage period, Delta Dental will mail a notification to you indicating any change in rates.

Enrollment and payment of premium is not a guarantee of claim payment. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office and the patient must be covered by a Delta Dental contract on the day services are completed. There are no refunds of premium dollars for this coverage.

Renewal of Coverage

Your coverage is automatically renewed at the end of your coverage period. Your coverage period is from your coverage start date until the end of the calendar year, unless otherwise noted.

If you choose to end your coverage, you must notify us in writing. Cancellation of coverage is effective on the last day of your most recent payment period, depending on the frequency of your payment (e.g. monthly, quarterly). **Please Note: If you cancel coverage, you must wait 12 months to reapply. If your new application is accepted, your coverage will begin on January 1 of the following year.** Delta Dental reserves the right to cancel coverage after appropriate notification due to non-payment of premium.

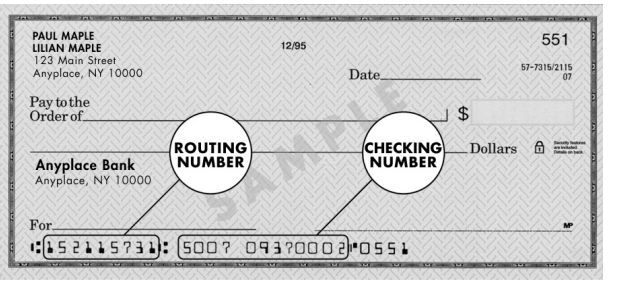
Coordination of Benefits (Additional Medical and Dental Coverage)

Please provide Delta Dental with any other medical or dental plan that covers you or your family member(s).

Method of Payment

This is a pre-paid dental insurance plan. Delta Dental offers two convenient payment options.

A. Direct Withdrawal from Bank Account – You may elect to have funds automatically withdrawn monthly from your bank account. Funds will be withdrawn no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. Please use this sample check as a guide when selecting direct withdrawal from your checking account. **Transactions that are returned for insufficient funds are subject to a $25 processing fee.**



B. Credit Card – You may opt for Delta Dental to charge your credit card, monthly. Your credit card will be charged no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. **Please Note: Transactions that are declined are subject to a $25 processing fee.**

Authorizing Statement

Please read the authorizing statement on the front of this enrollment form, and sign/date it. Delta Dental cannot process forms without an authorizing signature. You will receive your Subscriber ID card and benefit literature approximately 15 days before your coverage begins.

Please mail this form and your payment to Delta Dental of Rhode Island, P.O. Box 1517, Providence, RI 02901-1517.