DELTA DENTAL®

BROWN UNIVERSITY

BROWN

2020-2021 Dependent Enrollment Form

I. STUDENT INFORMATION

Student's Name: _____ Brown Banner ID: _____ Birthdate: _____
Last First Middle Initial mm/dd/yyyy

Address: _____ Telephone #: ( ) _____ Email: _____

II. DEPENDENT INFORMATION

Please enroll my: ☐ Spouse/Domestic Partner ☐ Child(ren) ☐ Spouse/Domestic Partner & Child(ren)

Dependent coverage is available only when the student is also insured under the Student Dental Insurance Plan and cannot exceed coverage purchased by the student. Dependents are not eligible for services at Health Services.

Name of Dependent (Last, First, Middle Initial)	Relationship to Student (Spouse/DP, Child)	Birthdate (mm/dd/yy)	Gender (M/F)

III. COVERAGE OPTIONS (please select):

☐ **A. Annual Coverage (effective 8/15/20 - 8/14/21)**
Payment Due: 9/15/2020
Coverage Effective: 8/15/2020 - 8/14/2021

☐ **B. Spring Term Coverage (effective 1/15/21 - 8/14/21)**
Payment Due: 2/15/2021
Coverage Effective: 1/15/2021 - 8/14/2021

	Annual Premium Coverage Option A	Subsidized Payment Coverage Option A (paid by Brown Univ.)	Balance Premium Due Coverage Option A (paid by student)	Annual Premium Coverage Option B	Subsidized Payment Coverage Option B (paid by Brown Univ.)	Balance Premium Due Coverage Option B (paid by student)
Spouse/Domestic Partner	$261.12	$195.84	$65.28	$152.32	$114.24	$38.08
One Child	$261.12	$195.84	$65.28	$152.32	$114.24	$38.08
More than One Child	$561.60	$421.20	$140.40	$327.60	$245.70	$81.90
Spouse/Domestic Partner & Child(ren)	$561.60	$421.20	$140.40	$327.60	$245.70	$81.90

The first payment must be submitted with this application no later than 9/15/20 for annual coverage or 2/15/21 for spring term coverage. Premiums are not prorated for enrollment forms received after the deadline.

IV. PAYMENT PROCESS AND ADDRESS

Make checks payable to Delta Dental of Rhode Island and send payments to:

Delta Dental of Rhode Island
10 Charles Street
Providence, RI 02904
ATTN: Accounts Receivable

Credit Card Authorization

Charge Amount: $ _____ ☐ **Visa** ☐ **Mastercard**

Card # _____ **Exp. Date** ____/____

Signature of Cardholder _____ Date _____

Notice to Students:
By signing below, the student acknowledge the following: 1) He/She elects to enroll his/her dependents as indicated on this enrollment form; 2) Premiums are not prorated other than as listed on this enrollment form; 3) He/She meets the eligibility requirements for this coverage; 4) If it is later determined that the student is not eligible, the premium will be refunded; 5) A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Dental Insurance Plan; 6) Other than for eligibility reasons, the premium is not refundable; 7) Please see the Billing Terms on the next page.

Signature _____ Date _____

Please keep a copy of this form for your records.

BILLING TERMS

1. Eligibility
You must be an active Brown University student to qualify for coverage. If you cease to be a Brown University student during the plan year, your dental coverage will continue until the end of the plan year.

2. Non-Guarantee of Payment
Enrollment and payment of premium is not a guarantee of claim payment. Payment is based on the Delta Dental allowance for each procedure. 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 of Rhode Island group contract on the day services are completed.

3. Payment Information
This is a pre-paid dental insurance plan. Your credit card will be charged at the beginning of each plan year.

4. Refunds
There are no refunds of premium dollars for this coverage.

5. Consent
By enrolling and making a claim for dental benefits, you agree on behalf of yourself and your covered dependents that dentists may release to Delta Dental and that Delta Dental may use and disclose your individually identifiable health information in accordance with Delta Dental's Notice of Privacy Practices. To view a copy of this notice, please visit www.deltadentalri.com.

6. Authorization
I certify that all information submitted to Delta Dental is true and correct to the best of my knowledge. I understand that the effective date and cancellation date of my insurance coverage will be determined by Delta Dental in accordance with the underwriting guidelines associated with this plan. I authorize Delta Dental to charge my credit card for the indicated payment.