DentaQuest

Application and Change Form for Individual & Family Dental Insurance

DentaQuest USA Insurance Company, Inc.
465 Medford Street
Boston, MA 02129-1454

Customer Service: 1-844-214-1279
www.DentaQuest.com

Please print or type. Required fields are starred (*) and must be completed to ensure enrollment. Subscriber must be age 18 or older and a legal resident of Texas.

1. *LAST NAME (Subscriber)	2. MIDDLE INITIAL (optional)	3. *FIRST NAME:	
4. * SOCIAL SECURITY NO.:	5. *DATE OF BIRTH:	6. *GENDER: M ☐ F ☐	
7. * HOME ADDRESS:	8. *CITY:	9. *STATE:	10. *ZIP:
11. BILLING ADDRESS: (if different)	12. CITY:	13. STATE:	14. ZIP:
15. * COUNTY:	16. *PHONE NUMBER:	17. *E-MAIL:	

ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY

If you are applying for **Subscriber Only** coverage, do not complete this section.

18. *FIRST NAME	19. MIDDLE INITIAL	20. *LAST NAME (if different from subscriber)	21. *SOCIAL SECURITY NUMBER	22. *DATE OF BIRTH	23. *GENDER
SPOUSE:					M ☐ F ☐
CHILDREN:					M ☐ F ☐
					M ☐ F ☐
					M ☐ F ☐
					M ☐ F ☐
					M ☐ F ☐

REASON FOR SUBMISSION

24. * CHECK ONE:
☐ New Application ☐ Reinstatement ☐ Termination ☐ Change

IF TERMINATION OR CHANGE, PLEASE COMPLETE BELOW (CHECK ALL THAT APPLY):

☐ Name _____ ☐ Phone Number _____
☐ Address _____ ☐ Email _____
☐ Coverage to: ☐ Subscriber ☐ Subscriber+Spouse ☐ Subscriber+Dependent/child ☐ Family ☐ Subscriber+Dependents/Children
☐ Add dependent(s) Name _____ Name _____
☐ Remove dependent(s) Name _____ Name _____
(Please use a separate page for additional dependents to be added or removed from plan.)

Termination (Reason):

☐ Relocated out of Texas ☐ Have other Dental Plan ☐ Other _____
☐ Non-payment ☐ Deceased

PLAN SELECTION

Please refer to the Summary Plan description to review your options

25. *SELECT ONE: ☐ Personal Dental Plan ☐ Personal Dental Plan Basic ☐ Personal Dental Plan Plus

To complete this application, you must review the information on page 2, sign in section 26 and mail items to Enrollment Department, DentaQuest, PO Box 502, Milwaukee, WI 53201-0502

PAYMENT INSTRUCTIONS

Once your enrollment is processed, your first invoice should be received within 5-7 business days. If you would prefer to receive future invoices electronically, you have the option to sign up for email notifications through our member portal.

For new coverage, your first invoice must be paid in full prior to the coverage period, for your policy to be in effect. For all future invoicing, your payments must be received in full no later than the 1st of the month. In the event the payment is returned for insufficient funds, a $25 service fee will be charges to your account and will be reflected on your next invoice.

To submit payment via check, please refer to the invoice detail and include the remit slip, which is the bottom portion of your invoice. Checks and remit slips should be mailed to the PO Box address on your next invoice.

If you would like to submit payment electronically, please visit the website listed on the invoice to access our member portal. You will have the option to submit a one-time payment from your bank account via automated clearing house (ACH) or credit card, or you can sign up for automatic payments going forward.

COVERAGE PERIOD
The initial term of your policy will be from the Effective Date to 11:59 p.m. on December 31 of the year in which it is issued. After the initial term, the policy will automatically renew each January 1 establishing a new Effective Date each year until a Change Form is submitted or until your policy is terminated in accordance with the terms of the policy. If you cancel coverage, you must wait at least one year after your cancellation before you can enroll again. DentaQuest reserves the right to change premium rates upon renewal of the policy.

Applications postmarked by the 20th of the month will become effective the 1st of the following month. Examples: Applications postmarked by June 20 will have an Effective Date of July 1. Applications postmarked June 21 will have an Effective Date of August 1.

AUTHORIZATION & TERMS

My application form, recorded Authorizations and any amendments shall be the basis for the policy. The insurance, if approved by DentaQuest USA Insurance Company, Inc. will be in force only when issued by DentaQuest USA Insurance Company, Inc. The premium must be paid when due. A change in my eligibility or the proposed dependent(s) after the completion of the application form and before the delivery of the contract may affect my eligibility for insurance with the company. I understand and agree that any information I provide through this application form process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. I understand that I have a right to receive a copy of this authorization.

I understand that this authorization is required in order to enable DentaQuest USA Insurance Company, Inc. to make eligibility or application determinations relating to me and/or my dependent(s). If I refuse to sign or revoke this authorization, DentaQuest USA Insurance Company, Inc. may refuse to consider my application for insurance. I understand that I may revoke this authorization at any time by notifying DentaQuest USA Insurance Company, Inc. in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: 465 Medford Street, Boston, MA 02129-1454. Such revocation will not be valid if DentaQuest USA Insurance Company, Inc. has taken action in reliance on the authorization. Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or if insured, 30 days after I am no longer an insured of DentaQuest USA Insurance Company, Inc. But in no event will this authorization be in effect for longer than 24 months from the date signed.

I agree that a photocopy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage or Certificate for dental Insurance, if required. I acknowledge that I have read the completed the application form. I attest that all statements and answers on this application form are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the application form, recorded Authorizations and/or any amendments may result in claim denial or contract rescission, subject to the Contestability of Coverage provision of the policy.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing 30 days prior written notice.

NOTICE: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss of benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

26. *Subscriber Signature:_____ Date: _____

Attention: (Agent) *if applicable*

☐ I have reviewed this application form to ensure that all required items have been completed.

I certify that:

☐ I personally saw the applicant. The applicant was asked each required question and the answer is truly and accurately recorded on the application form in the respective response area. The answers are true to the best of my knowledge.

The application was completed by the proposed subscriber or representative and the answers are true to the best of my knowledge.

_____
Licensed Resident Agent's Signature