Enrollment Form & Payment Authorization

MARS Associates

DELTA DENTAL®

Select a plan:

☐ Medium-PPO™ Only Plan #9001–01

☐ High-Delta Dental PPO™ Plan #9001–02

Effective Date (must be 1st of the month):

_____

Delta Dental of Colorado
PO Box 5468
Denver, CO 80217–5468
Individual Administration:
877–516–6512

Plan Enrollment

To enroll, complete this form, including premium payment information and authorization. Return completed forms by the 20th of the month to: **Delta Dental of Colorado, Attn.: Individual Administration, PO Box 5468, Denver, CO 80217–5468**. Fax to: **303–889–8695** or email to: **individual@ddpco.com**.

Subscriber Information

Complete for all enrollments/updates/changes

First Name: _____ **M.I.:** _____

Last Name: _____ ☐ **Male** ☐ **Female**

Social Security Number: _____ **Date of Birth:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Email Address: _____

Date of Retirement:** _____

*Or date of termination of COBRA coverage, if applicable.

Dependent 1 Full Name: _____

Relationship to Retiree: _____ **Date of Birth:** _____

Dependent 2 Full Name: _____

Relationship to Retiree: _____ **Date of Birth:** _____

Automatic Premium Payment Authorization

Your payment will be deducted automatically from your bank account on the 1st of each month. Please complete the following information. Be sure to sign the form before you submit it.

Name on Account: _____

Name of Bank: _____

Routing Number: _____
(First 9 digits on check)

Account Number: _____

Account Type: ☐ Checking ☐ Savings

Automatic Premium Payment Agreement

I hereby authorize Delta Dental of Colorado to initiate debit entries to my checking or savings account, as indicated above. I acknowledge that payment for the upcoming period will be deducted from my account on the 1st of the month. If the charge is declined for any reason, Delta Dental will attempt to charge me again on the 1st of the following month. If the charge is still declined, they will immediately terminate my coverage for nonpayment of premium, effective as of the last day of the grace period.

This authorization is to remain in full force and effect until Delta Dental of Colorado or its agent receives thirty (30) days written notice from me of its cancellation. The notification must be sent to Delta Dental of Colorado, **Attn.: Individual Administration, PO Box 5468, Denver, CO 80217–5468. Fax to: 303–889–8695 or email to: individual@ddpco.com**.

Signature of Authorized Account Holder: _____ **Date:** _____