DELTA DENTAL

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deltadentalvadip.org

VETERANS AFFAIRS DENTAL INSURANCE PROGRAM (VADIP)
Enrollment Authorization

SECTION 1	Enrollment Type

☐ **Veteran Enrollment** *(complete sections 2, 4 and 5; if adding a CHAMPVA beneficiary, complete section 3)*

☐ **CHAMPVA Beneficiary Enrollment** *(complete sections 2 - 5)*

SECTION 2	Veteran Information *(completion of this section is required)*

Veteran

Last Name: _____ MI: _____ First Name: _____

Social Security Number: _____ Date of Birth (mm/dd/yy)____/____/____ Gender ☐ M ☐ F

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____ Country: _____

Home Phone: ( )_____ Email: _____

☐ **Yes**, *please email me instructions to access my Welcome Packet materials online.*

SECTION 3	CHAMPVA Beneficiary Information

Primary CHAMPVA Beneficiary

Last Name: _____ MI: _____ First Name: _____

Social Security Number: _____ Date of Birth *(mm/dd/yy)*___/___/___ Gender ☐ M ☐ F

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____ Country: _____

Home Phone: ( )_____ Email: _____

☐ **Yes**, *please email me instructions to access my Welcome Packet materials online.*

List additional CHAMPVA beneficiaries:

Last Name	First Name	Gender	Date of Birth *(mm/dd/yy)*	Social Security Number	Address
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			

SECTION 4	**Premium Prepayment Amount** *(completion of this section is required)*

Premium Prepayment - *Initial payment of a one-month premium must be sent with your completed Enrollment Authorization. Premium rates are available at* ***deltadentalvadip.org****. Please include the Veteran's or primary CHAMPVA beneficiary's social security number (SSN) on the memo portion of the check or money order. Checks and money orders should be made payable to DDIC -- Delta Dental Insurance Company.*

Recurring Payment – *Ongoing payment of your monthly premiums through electronic funds transfer (EFT) from your savings or checking account* ***is required*** *for enrollment. Please complete the Authorization for Electronic Funds Transfer included on the last page of this Enrollment Authorization.*

Note: *If a payment (initial or recurring) is returned for insufficient funds, you authorize Delta Dental to electronically debit your bank account for the original amount of the transaction, as well as a returned fee, up to the maximum amount allowed by law.*

Choose your plan *(visit* ***deltadentalvadip.org*** *to compare your plan options)*

☐ Standard	☐ Enhanced	☐ Comprehensive

Amount of Premium Prepayment: _____

Method of Premium Prepayment: ☐ Check/money order ☐ Visa® ☐ MasterCard® ☐ Discover®

Credit Card Number: _____

Expiration Date *(mm/yy)* _____/_____ Security Code: _____

Name of Cardholder *(as it appears on credit card)*: _____

Billing Address of
Cardholder *(if different from mailing address):* _____

X Authorized Signature
_____

SECTION 5	**Enrollment Agreement** *(completion of this section is required)*

This Enrollment Authorization must be signed below by the Veteran or CHAMPVA beneficiary. An individual with power of attorney (POA) may sign for either; however, the entire copy of the valid POA must be submitted with the Enrollment Authorization.

This is my application for coverage under the Veterans Affairs Dental Insurance Program (VADIP). I understand that enrollment is subject to verification of eligibility and receipt of one month's premium payment. I understand that coverage does not begin upon deposit of my initial premium payment. Coverage will be effective the first day of the month after receipt and acceptance of my application. I must remain enrolled for a minimum of 12 months. Termination is not automatic upon fulfillment of this period and must be initiated by the subscriber. I understand that I am responsible for full payment of any dental services provided prior to the effective date or after the termination date of the policy.

Veteran or CHAMPVA
Beneficiary Signature_____ Date_____

DELTA DENTAL®

VETERANS AFFAIRS DENTAL INSURANCE PROGRAM (VADIP)
Authorization for Electronic Funds Transfer (EFT)

Electronic funds transfer (EFT) is an easy and efficient method of automatically paying your monthly premium and is required for enrollment in VADIP. To get started with EFT, complete this form and return it to Delta Dental at the address below, or register for the secure Consumer Toolkit® and log on to complete your information online.

Delta Dental of California
Federal Government Programs
PO Box 537009
Sacramento, CA 95853-7009

Customer Service (toll-free): 855-460-3302
Website: **deltadentalvadip.org**

REQUIRED INFORMATION

Customer Information

Veteran/CHAMPVA Member Social Security Number: _____ Phone Number: ( ) _____

Email Address: _____

Name: _____

Address: _____

City, State, ZIP: _____

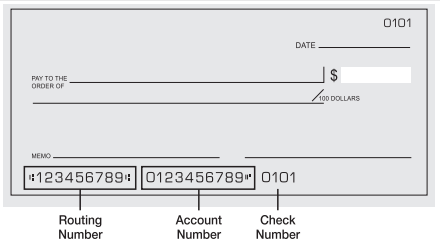
Financial Institution Information

Name of Financial Institution: _____

Name on Bank Account: _____

☐ Checking ☐ Savings

Transit Routing (ABA) Number (always 9 digits): ☐☐☐☐☐☐☐☐☐



Bank Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Note: Please confirm with your banking institution that your account can accept ACH debits and that you have provided the correct ABA for ACH transactions.

Your signature below acknowledges you have read and understand the following important information:

Amount of payment: The appropriate premium amount will be deducted from your bank account on the seventh of every month or the next business day (depending on your financial institution).

Right to stop automatic payments: You have the right to stop these payments at any time; however, doing so may adversely affect your VADIP enrollment. To stop your automatic payments, contact us at the address above. Phone/written notice of cancellation must be received three business days before the next payment due date. You must provide information for an alternative payment method (i.e., a new bank account) at the time you cancel your current payment method. Failure to do so in a timely manner could result in the termination of your account and a 12-month re-enrollment lockout.

Your responsibility: This EFT arrangement will be terminated if your financial institution refuses payment due to insufficent funds or other reason. Second attempts to deduct payment will not be made using the same payment method information. If we receive information for a new payment method after the attempt to deduct payment has been refused, we will use the new information provided to attempt a deduction for the past-due balance.

I authorize Delta Dental to withdraw funds from my bank account for payment of my monthly dental program premiums according to the terms outlined above. If the above-noted payment date for EFT falls on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it by phone or in writing, and I agree to notify Delta Dental by phone or in writing of any changes in my account information or termination of this authorization at least three days prior to the next billing date. I certify that I am an authorized user of this bank account and that I will not dispute the scheduled payments with my financial institution provided the transactions correspond to the terms indicate in this authorization form.

Signature: _____ Date: _____